RUC Recommendations for CPT 2008 Volume I

RUC Meetings
September 2006, February 2007 and April 2007

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2008

TABLE OF CONTENTS
Volume I

Anesthesia for Radiologic Spine Procedures	1
Soft Tissue Brachytherapy Implant Placement	2
Application of Cranial Tongs	3
External Fixation	4
Computer Navigation	5
Temporomandibular Joint Manipulation	6
Interstitial Fiducial Marker Placement	7
Three Column Osteotomy	8
Internal or External Fixation – Shoulder/Elbow	9
Epicondylitis Procedures	10
Internal or External Fixation – Elbow/Hand	11
Femoral Head Fracture Treatment	12
Internal or External Fixation – Hip/Knee	13
Open Knee Osteochondral Autograft	14
Posterior Malleolar Fracture Treatment	15
Fibula Malunion	16
Internal or External Fixation – Foot/Ankle	17

Volume II

Open Osteochondral Talus Graft	18
Arthroscopic Biceps Tenodesis	19

Subtalar Arthroscopy	20
Insert Emergency Airway	21
Add-On Maze	22
Valve Sparing Aortic Annulus Reconstruction	23
Wireless Pressure Sensor Implantation and Study	24
Brachial-Ulnar Bypass Graft	25
Non-Implantable Venous Access Device Blood Draws	26
Arterial Catheterization	27
Head and Neck Interstitial Brachytherapy Needle or Catheter Placement	28
Peritoneal Tumor Ablation	29
G-, J-, G-J, C-Tube Procedures	30
Transuretheral Ureteral Stent Tube Exchange and Removal	31
Intra-Abdominal Voiding Pressure	A
Pelvic Interstitial Brachytherapy Needle or Catheter Placement	B
Percutaneous Renal Tumor Cryotherapy	C
Prostate Laser Enucleation	D
Laparoscopic Paravaginal Defect Repair	E
Laparoscopic Total Hysterectomy	F
Viterectomy with Epiretinal Membrane Stripping	G
Retinopathy Treatment	H
Nasolacrimal Duct Balloon Catheter Dilation	I
Cardiac MRI	J
Brain and Cerebrospinal Fluid Imaging	K

PET Imaging	L
Manual Microdisection	M
Immune Globulin Subcutaneous Infusion	N
Insertion and Placement of Heart Catheter	O
Allergy Test Interpretation	P
Electronic Analysis of Implanted Neurostimulator Pulse Generator System	Q
Ocular Photoscreening	R
Initial Day Hospital Neonate Care	S
Team Conference	T
Non-Face-to-Face Physician Services	U
Smoking Cessation	V
Alcohol, Drug Screening and Brief Intervention	W

AMA
AMERICAN
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May 30, 2007

Leslie Norwalk
Acting Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Norwalk:

It is with pleasure that I submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), work relative value and direct practice expense input recommendations for new and revised codes for CPT 2008. In addition, I submit the work relative value and direct practice expense input recommendations for codes identified in the third Five-Year Review. At this time, the RUC is also submitting physician time data corrections and updates for existing services as well as comments regarding specific payment policies for consideration in the 2008 Medicare Physician Payment Schedule *Proposed Rule*. The RUC Health Care Professionals Advisory Committee Review Board is separately forwarding its recommendations to CMS.

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CPT 2008 New and Revised Codes

Enclosed are two binders of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2008 is 332, including 118 additions, 186 revisions and 28 deletions. Thirty of these new and revised codes are not payable on the RBRVS (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes. In addition, seven of these new codes were reviewed by the RUC HCPAC Review Board as these codes describe services provided by non-MD/DO health professionals. Of the remaining 267 new and revised codes, the RUC submits 266 recommendations at this time. The RUC does not submit a recommendation for code 99174 *Ocular photoscreening with interpretation and report, bilateral*, due to a lack of specialty interest in developing recommendations.

The RUC is recommending that eleven codes be carrier priced in 2008. In addition, the RUC recommends interim values for 15 codes. The summary table in the attached binders and in the enclosed CD, specifically identifies the G-, J-, G-J, C-Tube Procedures (49441-49465 and 43760), Femoral Head Fracture (27267-27269) and Computer Navigation (20985-20987) to be re-reviewed at the September 2007 RUC Meeting. I will send any new information related to these services to CMS immediately following the meeting.

Also included in these binders and on the enclosed CD, are physician time data for each of the CPT codes reviewed at the September 2006, February 2007 and April 2007 RUC meetings. The RUC continues to review physician time data to ensure that the most accurate data is utilized in the CMS practice expense methodology.

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Enclosed in a separate binder are recommendations for nine issues identified for review in the most previous Five-Year Review. These issues include:

- Partial Mastectomy (19301)
- Insertion of Heart Pacemaker (33207)
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Also included with these recommendations are physician time data for each of the Five-Year Review issues discussed.

CMS Requested Review of Practice Expense Inputs

Enclosed are direct practice expense refinement recommendations for eight issues as requested by CMS and reviewed at the February and April 2007 meetings of the RUC.

The issues include:

- Transcatheter Placement of Intravascular Stent(s) (37205, 37206, 75960)
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Other RUC Recommendations

As CMS develops the Proposed Rule for the 2008 Physician Payment Schedule, I ask that you consider several pending RUC recommendations.

Anesthesia Recommendations
CMS requested a RUC review of anesthesia services in the *Final Rule* published in the December 1, 2006 *Federal Register*. CMS stated that, "Although anesthesia services are paid under the Physician Fee Schedule, they are paid on the basis of an anesthesia code-specific base unit and time units that vary based on the anesthesia time of the case. Since anesthesia services do not have a work values per codes as do other medical services, a work value must be imputed for each anesthesia code. As a result of its relationship with the RUC and the past recommendations for valuing anesthesia services, which were discussed in detail in the June 29, 2006 Proposed Notice, the American Society of Anesthesiologists (ASA) requested that we address the valuation of anesthesia services reported under CPT code 00100 through 01999. The ASA furnished an analysis that builds on the methodology used in the last 5 Year Review for the valuation of work for anesthesia services. We recommend that the valuation of anesthesia services, namely the proposed valuation of the post-induction time, be referred to the AMA RUC for review and consideration."

To address this request the RUC formed the Anesthesia Workgroup which reviewed this issue at length during two conference calls and three face-to-face meetings. Based on the extensive review of all the building block components and validation of Post-Induction

Period Procedure Anesthesia (PIPPA) work by surgeons on the Workgroup familiar with anesthesia services associated with their specialty, the Workgroup reached unanimous agreement that the revised model predicts anesthesia undervaluation. **The RUC recommends to CMS that Anesthesia work is undervalued by 32%.**

The RUC also identified three anesthesia services that may be misvalued based on this analysis and recommend that CMS allow review of the base units for at an upcoming RUC meeting:

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Supporting documents including the specific recommendations made by the Anesthesia Workgroup, the anesthesia quintile intensity retrofit calculations, the anesthesia regression versus quintile comparison, and the final anesthesia services calculations using the building block methodology as approved by the RUC, are enclosed in the Other RUC Recommendations Binder.

Budget Neutrality – Work Adjuster
The Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. To limit the increases in Medicare expenditures as mandated by the statute, CMS has applied a new "work adjuster" to ensure budget neutrality following the implementation of the improved work RVUs from the most recent Five-Year Review of the RBRVS. **The RUC argues that applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward and strongly urges CMS to apply the necessary adjustments to the conversion factor.**

From 1998 to present, CMS has implemented all work neutrality adjustments by adjusting the Medicare conversion factor. CMS did not explain why it altered this long utilized method and moved backward to an approach that the agency itself remarked was inappropriate. The RUC requests that CMS consider the history and these additional arguments and apply budget neutrality to the conversion factor:

1.) Adjusting the conversion factor does not affect the relativity of services reflected in the recommended RVUs. Adjusting the RVUs has the potential to inappropriately affect relativity and dampen the improvements to the E/M services valuation. CMS has publicly lauded the RUC for recommending these increases to E/M and we would surmise that the agency would want to achieve the full benefit of these improvements.

2.) An adjustment in the Medicare conversion factor is preferable because it has less impact on other payers who use the Medicare RVUs. That is, an adjustment in the Medicare conversion factor will not necessarily affect the payment rates of other payers who use the Medicare RVUs and their own conversion factors. However, any adjustment in the RVUs will impact the payment rates of such payers. The payment rates of payers who peg their rates to a percentage of Medicare will be affected regardless. The RUC believes that CMS must consider such "ripple effects" as it decides how to adjust for work neutrality.

3.) The RUC believes an adjustment to the conversion factor recognizes that budget neutrality is mandated for monetary reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality

4.) Applying the work neutrality adjustment to the conversion factor would coincide with CMS' current mission of making Medicare payment transparent.

Equipment Assumptions – Equipment Utilization Data
CMS currently utilizes an interest rate of 11% in pricing medical equipment. CMS has acknowledged that this rate is too high and requested comments regarding the appropriate interest rate. The RUC also discussed and agreed that the interest rate currently utilized is too high. The RUC agreed that the interest rate should fluctuate according to market conditions, rather than a fixed rate. The cost of capital is a legitimate expense of a physician's office and should be linked to prevailing rates. **CMS should adjust the 11% cost of capital rate to a market competitive rate.**

Equipment Assumptions – Cost of Capital Assumptions
CMS requested information on how it should reflect the utilization rate, particularly for high cost equipment. Currently, CMS uses a 50% utilization rate for all equipment. The RUC has discussed whether there should be a different rate for all equipment or just for the equipment set by specific cost thresholds. The RUC indicated that the cost of capital may not have a direct linear relationship with equipment utilization. Further, the RUC discussed whether consideration should be given to impacts on rural payment, as utilization rates may not be as high as in urban areas. The RUC recommends that the existing CMS standard of 50% utilization rate for all equipment is not an accurate measure. **CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations.**

Practice Expense Inputs - Supplies
The Practice Expense Subcommittee and the RUC in an effort to continually refine the RUC's process of developing practice expense recommendations agreed that some

mechanism should be in place to distinguish high priced disposables medical supplies, from the practice expense methodology so that the inequities of the scaling factors do not cause as many anomalies in the practice expense specialty pools and in practice expense relative values. The RUC recommends:

CMS set a specific reasonable threshold for the creation of J codes on high priced disposable medical supplies, and that an impact analysis be performed to find out how individual specialty's and practice expense pools would be affected. In addition, medical supplies used in the practice expense methodology, priced at or above $200, should be re-priced on an annual basis.

Members of the subcommittee believed that an initial reasonable threshold could be $250.00.

Professional Liability Insurance
In 1999, and consistently since 2004, the RUC has urged CMS to address a significant problem in the PLI RVU determinations for services with a technical component and professional component. The current CMS methodology generates a higher PLI relative value for the technical component portion than the professional component. One particularly poignant example of this inverse relationship is found in 77057, *Screening mammography, bilateral (2-view film study of each breast)* For this service, carrying a considerable amount of risk in screening for cancer, the PLI RVU for the professional component is .03, while the technical component is .07. The professional component PLI RVU includes the interpretation of results and the most significant amount of liability, but is valued less than half of the technical component PLI RVU, which accounts for only the risk posed by the equipment and the imaging process.

In the Final Rule for the 2005 Physician Payment Schedule, CMS responded to the continuing RUC comments as follows:

> *Physician work RVUs are used to adjust for risk of service. Because technical component services do not have physician work RVUs, they are still valued using charge-based RVUs instead of the resource-based malpractice RVU methodology. We look forward working with the ACR and the other interested specialty organizations to examine alternative methodologies that would allow technical component services to also reflect resource-based malpractice RVUs.*

At a minimum, CMS should appropriately reallocate PLI RVUs within the physician fee schedule by accepting the RUC interim recommendation to establish the technical component PLI RVU to be equivalent to the professional component PLI RVU for each

CPT code. **A more appropriate strategy would develop a methodology to ensure that the technical component PLI RVUs reflect resource-based professional liability costs.**

CMS Definition of Pre-time
The RUC requests that CMS consider a modification to the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology. The current CMS definition of pre-service time for physicians is as follows:

Pre-service period
The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- *Hospital admission work-up.*
- *The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.*
- *Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other "non-skin-to-skin" work in the OR.*

The following services are ***not included****:*

- *Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).*
- *Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).*
- *Mandated services (reported with modifier -32).*

The RUC recommends that the physician pre-service period instead begin when the decision for surgery is made. Physicians may engage in many of these pre-service activities (eg, review of records, communicating with other professionals, etc) prior to the day before the operative procedure.

Five Year Review Identification Workgroup and New Technology/Services Identification/Review Process

Based on previous MedPAC discussions and recommendations to Congress, CMS led initiatives to identify misvalued services, and its own mission to ensure correct valuation of all codes, the RUC concurred that there should be a process to identify such codes.

This workgroup initially convened in October 2006 and February 2007. Through this process, the RUC has begun to identify services incorporating new technology, which are likely to change in value, for subsequent review in order to minimize future misvaluation. The RUC is also developing other objective measures to identify misvalued services.

At its April 2006 meeting, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. First, a code is identified as a new technology/service at the RUC meeting in which it is initially reviewed. Second, the code is identified as a new technology/service in the next version of the RUC database with the date it is to be re-reviewed. Third, the code will be reviewed according to this schedule (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available. A flow chart providing a detailed description of this process is below. The RUC has already identified 78 of these procedures through its new and revised process. A table of these codes identified as new technology/services has been attached.

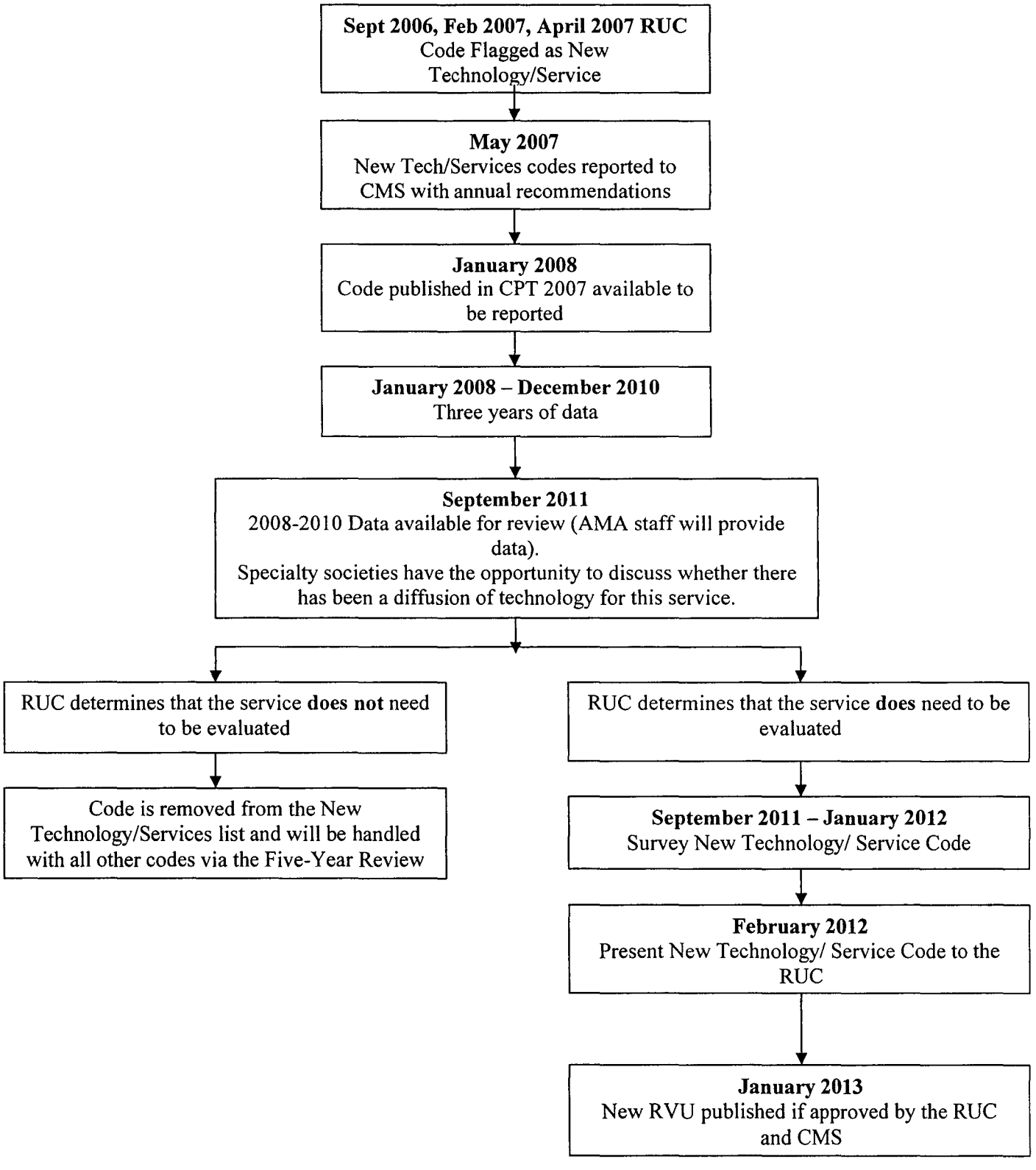
We appreciate your consideration of the RUC's recommendations. You may contact Sherry Smith at the AMA with any questions regarding this submission

Sincerely,

William L. Rich, III, MD, FACS

cc: Gaysha Brooks
Rick Ensor
Edith L. Hambrick, MD
James Hart
Ken Simon, MD
Sherry Smith
Pam West, PT
RUC Participants

Chart: Flow Chart of RUC Process to Identify/Review New Technology/Services



AMA
AMERICAN MEDICAL ASSOCIATION

May 30, 2007

Leslie Norwalk
Acting Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Norwalk:

It is with pleasure that we submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board, work relative value and direct practice expense inputs for new and revised codes for CPT 2008.

These work relative value and direct practice expense input recommendations address the following new codes:

- Non Face-to-Face Qualified Healthcare Professional Services
- Team Conferences – Participation by Non-Physician Qualified Health Care Professional
- Standardized Cognitive Performance Testing

The CPT Editorial Panel also developed new codes corresponding s for the non face-to-face services and team conference services provided by physicians (MDs/DOs). The RUC reviewed and submitted recommendations on the physician (MD/DO) services only. The HCPAC independently reviewed and submitted separate recommendations on the non-physicians services.

The RUC HCPAC Review Board looks forward to continued CMS representation at our meetings and your effort to ensure a fair review of the enclosed recommendations.

If you have any questions please contact AMA staff, Susan Clark, at (312) 464-4308 or via e-mail at Susan.Clark@ama-assn.org.

Sincerely,

Arthur R. Traugott, MD

Mary Foto, OTR

cc: Gaysha Brooks
Rick Ensor
Edith L. Hambrick, MD
James Hart
Ken Simon, MD
Sherry Smith
Pam West, DPT

HCPAC Review Board

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In 1999, and consistently since 2004, the RUC has urged CMS to address a significant problem in the PLI RVU determinations for services with a technical component and professional component. The current CMS methodology generates a higher PLI relative value for the technical component portion than the professional component. One particularly poignant example of this inverse relationship is found in 77057, *Screening mammography, bilateral (2-view film study of each breast)* For this service, carrying a considerable amount of risk in screening for cancer, the PLI RVU for the professional component is .03, while the technical component is .07. The professional component PLI RVU includes the interpretation of results and the most significant amount of liability, but is valued less than half of the technical component PLI RVU, which accounts for only the risk posed by the equipment and the imaging process.

In the Final Rule for the 2005 Physician Payment Schedule, CMS responded to the continuing RUC comments as follows:

> *Physician work RVUs are used to adjust for risk of service. Because technical component services do not have physician work RVUs, they are still valued using charge-based RVUs instead of the resource-based malpractice RVU methodology. We look forward working with the ACR and the other interested specialty organizations to examine alternative methodologies that would allow technical component services to also reflect resource-based malpractice RVUs.*

At a minimum, CMS should appropriately reallocate PLI RVUs within the physician fee schedule by accepting the RUC interim recommendation to establish the technical component PLI RVU to be equivalent to the professional component PLI RVU for each

CPT code. **A more appropriate strategy would develop a methodology to ensure that the technical component PLI RVUs reflect resource-based professional liability costs.**

CMS Definition of Pre-time
The RUC requests that CMS consider a modification to the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology. The current CMS definition of pre-service time for physicians is as follows:

Pre-service period
The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- *Hospital admission work-up.*
- *The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.*
- *Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other "non-skin-to-skin" work in the OR.*

The following services are ***not included****:*

- *Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).*
- *Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).*
- *Mandated services (reported with modifier -32).*

The RUC recommends that the physician pre-service period instead begin when the decision for surgery is made. Physicians may engage in many of these pre-service activities (eg, review of records, communicating with other professionals, etc) prior to the day before the operative procedure.

Five Year Review Identification Workgroup and New Technology/Services Identification/Review Process

Based on previous MedPAC discussions and recommendations to Congress, CMS led initiatives to identify misvalued services, and its own mission to ensure correct valuation of all codes, the RUC concurred that there should be a process to identify such codes.

This workgroup initially convened in October 2006 and February 2007. Through this process, the RUC has begun to identify services incorporating new technology, which are likely to change in value, for subsequent review in order to minimize future misvaluation. The RUC is also developing other objective measures to identify misvalued services.

At its April 2006 meeting, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. First, a code is identified as a new technology/service at the RUC meeting in which it is initially reviewed. Second, the code is identified as a new technology/service in the next version of the RUC database with the date it is to be re-reviewed. Third, the code will be reviewed according to this schedule (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available. A flow chart providing a detailed description of this process is below. The RUC has already identified 78 of these procedures through its new and revised process. A table of these codes identified as new technology/services has been attached.

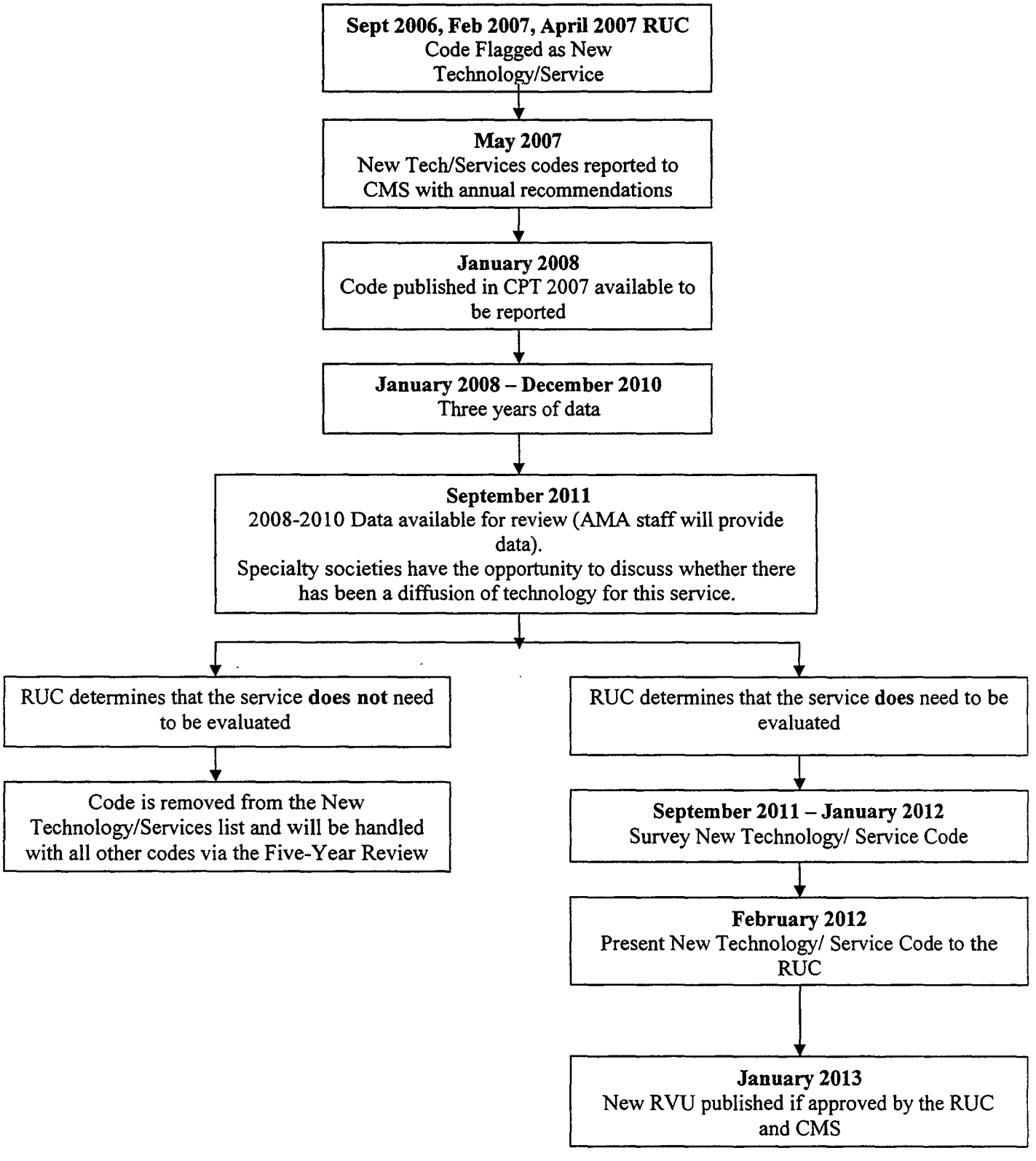
We appreciate your consideration of the RUC's recommendations. You may contact Sherry Smith at the AMA with any questions regarding this submission

Sincerely,

William L. Rich, III, MD, FACS

cc: Gaysha Brooks
Rick Ensor
Edith L. Hambrick, MD
James Hart
Ken Simon, MD
Sherry Smith
Pam West, PT
RUC Participants

Chart: Flow Chart of RUC Process to Identify/Review New Technology/Services



CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr-06	Fibroadenoma Cryoablation	11	September 2010	CPT 2007
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr-06	Percutaneous Intradiscal Annuloplast	13	September 2010	CPT 2007
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels	Apr-06	Percutaneous Intradiscal Annuloplast	13	September 2010	CPT 2007
22857	Total disc arthroplasty (artificial disc), including anterior approach, including diskectomy to prepare interspace (other	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
22862	Revision including replacement of total disc arthroplasty (artificial disc) including anterior approach, lumbar, single	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
22865	Removal of total disc arthroplasty (artificial disc), including anterior approach, lumbar, single interspace	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
32998	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleur or chest wall when involved	Apr-06	Percutaneous RF Pulmonary Tumor Ablation	15	September 2010	CPT 2007
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
43648	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum; revision or removal of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb-06	Functional MRI	15	September 2010	CPT 2007
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb-06	Functional MRI	15	September 2010	CPT 2007
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based	Sep-05	Stereotactic Radiation Tx Delivery	7	September 2010	CPT 2007
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); linear accelerator based	Sep-05	Stereotactic Radiation Tx Delivery	7	September 2010	CPT 2007
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr-06	Stereotactic Body Radiation Therapy	B	September 2010	CPT 2007

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
77435	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	Apr-06	Stereotactic Body Radiation Therapy	B	September 2010	CPT 2007
88384	Array-based evaluation of multiple molecular probes; 11 through 50 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2009	CPT 2006
88385	Array-based evaluation of multiple molecular probes; 51 through 250 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2009	CPT 2006
88386	Array-based evaluation of multiple molecular probes; 251 through 500 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2009	CPT 2006
96020	Neurofunctional testing selection and administration during non-invasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report	Feb-06	Functional MRI	15	September 2010	CPT 2007
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb-06	Whole Body Integumentary Photography	19	September 2010	CPT 2007
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements	Apr-06	Anticoagulant Management Services	I	September 2010	CPT 2007
99364	Anticoagulant management for a patient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of three INR measurements)	Apr-06	Anticoagulant Management Services	I	September 2010	CPT 2007
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb-07	Manual Microdisection	12	September 2011	CPT 2008
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb-07	Manual Microdisection	12	September 2011	CPT 2008
99441	Telephone Evaluation and Management, 5-10 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
99442	Telephone Evaluation and Management, 11-20 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008
99443	Telephone Evaluation and Management, 21-30 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008
33257	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure); performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
33258	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
33259	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
29828	Tenodesis of long tendon of biceps	Apr-07	Arthroscopic Biceps Tenodesis	17	September 2011	CPT 2008
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr-07	Cardiac MRI	F	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
75562	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75564	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
20985	Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
20986	Computer assisted surgical navigational procedure for musculoskeletal procedures; with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound), (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
20987	Computer assisted surgical navigational procedure for musculoskeletal procedures; with image-guidance based on pre-operative images (eg, CT, MRI), (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment of new subcutaneous infusion site(s)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr-07	Laparoscopic Paravaginal Defect Repair	C	September 2011	CPT 2008
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr-07	Nasolacrimal Duct Balloon Catheter Dilation	E	September 2011	CPT 2008
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr-07	Percutaneous Renal Tumor Cryotherapy	A	September 2011	CPT 2008
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	September 2011	CPT 2008
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr-07	PET Imaging	G	September 2011	CPT 2008
78813	Positron emission tomography (PET) imaging; whole body	Apr-07	PET Imaging	G	September 2011	CPT 2008
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	September 2011	CPT 2008
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr-07	PET Imaging	G	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr-07	PET Imaging	G	September 2011	CPT 2008
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)	Apr-07	Valve Sparing Aortic Annulus Reconstruction	24	September 2011	CPT 2008
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data (List in addition to the code for the primary procedure)	Apr-07	Wireless Pressure Sensor Implantation	25	September 2011	CPT 2008
93982	Non-invasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Apr-07	Wireless Pressure Sensor Implantation	25	September 2011	CPT 2008
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58571	Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less; with removal of tubes and/or ovary(s)	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 gram	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58573	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams; with removal of tubes and/or ovary(s)	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
95966	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 5-10 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95967	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 11-20 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95968	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 21-30 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008

Specialty and Acronym

Society	Acronym
AMA CPT Editorial Panel	AMA
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians & Investigators	AAPPI
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS

Society	Acronym
American College of Cardiology	ACC
American College of Chest Physicians	ACCP
American College of Emergency Physicians	ACEP
American College of Medical Genetics	ACMG
American College of Obstetricians and Gynecologists	ACOG
American College of Occupational and Environmental Medicine	ACOEM
American College of Physicians	ACP
American College of Preventive Medicine	ACPM
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Dietetic Association	ADiA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Institute of Ultrasound in Medicine	AIUM
American Medical Association	AMA
American Medical Directors Association	AMDA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Association	AOA-Ortho
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Roentgen Ray Society	ARRS

Society	Acronym
American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
American Society of Cytopathology	ASC
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Maxillofacial Surgeons	ASMS
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Ophthalmic Plastic and Reconstructive	ASOPRS
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP

Society	Acronym
Congress of Neurological Surgeons	CNS
Contact Lens Society of America	CLSA
Infectious Diseases Society of America	IDSA
International Spinal Injection Society	ISIS
International Spine Intervention Society	ISIS
Joint Council of Allergy Asthma and Immunology	JCAAI
Joint Council of Allergy, Asthma and Immunology	JCAAI
Medical Group Management Association	MGMA
MedPAC	MedPAC
National Association of Social Workers	NASW
North American Spine Society	NASS
Practice Expense Review Committee (PERC)	PERC
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine	SNM
Society of Thoracic Surgeons	STS
The Endocrine Society	TES
The Triological Society	TTS

CPT 2008 RUC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
01905	XXX	D	Feb07	20	Anesthesia for Radiologic Spine Procedures		Apr07	04	ASA				☑		☐
01935	XXX	N	Feb07	20	Anesthesia for Radiologic Spine Procedures	P1	Apr07	04	ASA	5.00	5.00		☑		☐
01936	XXX	N	Feb07	20	Anesthesia for Radiologic Spine Procedures	P2	Apr07	04	ASA	5.00	5.00		☑		☐
11008	ZZZ	R	Oct06	05	Mesh Implantation		Editorial			5.00	5.00	Yes	☑		☐
20555	000	N	Feb07	22	Soft Tissue Brachytherapy Implant Placement	Q1	Apr07	05	ASTRO	8.00	6.00		☑		☐
20660	000	R	Feb07	05	Application of Cranial Tongs	DD1	Apr07	19	AAOS, AANS/CNS	2.51	4.00		☑	Modifier -51 Exempt List Issue - Should not be Modifier - 51 exempt	☐
20690	090	R	Feb07	05	External Fixation	R1	Apr07	06	AAOS, AOFAS	8.65	8.65		☑	Five Year Review Issue, Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
20692	090	R	Feb07	05	External Fixation	R2	Apr07	06	AAOS, AOFAS	16.00	16.00		☑	Five Year Review Issue, Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
20930	ZZZ	R	Feb07	05	Modifier -51		Editorial			0.00	0.00	Yes	☑		☐
20931	ZZZ	R	Feb07	05	Modifier -51		Editorial			1.81	1.81	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
20936	ZZZ	R	Feb07	05	Modifier -51		Editorial			0.00	0.00	Yes	☑		☐
20937	ZZZ	R	Feb07	05	Modifier -51		Editorial			2.79	2.79	Yes	☑		☐
20938	ZZZ	R	Feb07	05	Modifier -51		Editorial			3.02	3.02	Yes	☑		☐
20985	ZZZ	N	Feb07	99	Computer Navigation	S1	Apr07	07	AAOS	2.50	2.50		☑		☑
20986	ZZZ	N	Feb07	99	Computer Navigation	S2	Apr07	07	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☑
20987	ZZZ	N	Feb07	99	Computer Navigation	S3	Apr07	07	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☑
21073	090	N	Jun06	09	Temporomandibular Joint Manipulation	A1	Oct06	07	AOMS	4.15	3.33		☑		☐
22102	090	R	Jun06	10	Posterior Distraction Device Insertion		Editorial			10.88	10.88	Yes	☑		☐
22206	090	N	Feb07	27	Three Column Osteotomy	U1	Apr07	09	NASS, AAOS, AANS/CNS	37.00	37.00		☑		☐
22207	090	N	Feb07	27	Three Column Osteotomy	U2	Apr07	09	NASS, AAOS, AANS/CNS	36.50	36.50		☑		☐
22208	ZZZ	N	Feb07	27	Three Column Osteotomy	U3	Apr07	09	NASS, AAOS, AANS/CNS	9.66	9.66		☑		☐
22840	ZZZ	R	Jun06	10	Posterior Distraction Device Insertion		Editorial			12.52	12.52	Yes	☑		☐
22840	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.52	12.52	Yes	☑		☐
22841	ZZZ	R	Feb07	05	Modifier -51		Editorial			0.00	0.00	Yes	☑		☐
22842	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.56	12.56	Yes	☑		☐
22843	ZZZ	R	Feb07	05	Modifier -51		Editorial			13.44	13.44	Yes	☑		☐
22844	ZZZ	R	Feb07	05	Modifier -51		Editorial			16.42	16.42	Yes	☑		☐
22845	ZZZ	R	Feb07	05	Modifier -51		Editorial			11.94	11.94	Yes	☑		☐

CPT Code	Global Period	ding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comme.	New Tech/Service
22846	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.40	12.40	Yes	☑		☐
22847	ZZZ	R	Feb07	05	Modifier -51		Editorial			13.78	13.78	Yes	☑		☐
22848	ZZZ	R	Feb07	05	Modifier -51		Editorial			5.99	5.99	Yes	☑		☐
22851	ZZZ	R	Feb07	05	Modifier -51		Editorial			6.70	6.70	Yes	☑		☐
22851	ZZZ	R	Jun06	10	Posterior Distraction Device Insertion		Editorial			6.70	6.70	Yes	☑		☐
23515	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F10	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	11.00	11.00		☑	Five Year Review Issue	☐
23585	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F3	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	16.25	16.25		☑	Five Year Review Issue	☐
23615	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F4	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	15.00	14.00		☑	Five Year Review Issue	☐
23616	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F5	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	21.00	21.00		☑	Five Year Review Issue	☐
23630	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F6	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	12.00	12.00		☑	Five Year Review Issue	☐
23670	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F7	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	14.00	14.00		☑	Five Year Review Issue	☐
23680	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F8	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	15.00	15.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
24350	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24351	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24352	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24354	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24356	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24357	090	N	Feb07	28	Epicondylitis Procedures	V1	Apr07	10	AAOS, ASSH	5.32	5.32		☑		☐
24358	090	N	Feb07	28	Epicondylitis Procedures	V2	Apr07	10	AAOS, ASSH	6.54	6.54		☑		☐
24359	090	N	Feb07	28	Epicondylitis Procedures	V3	Apr07	10	AAOS, ASSH	8.86	8.86		☑		☐
24545	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F9	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	15.00	15.00		☑	Five Year Review Issue	☐
24546	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F11	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	22.00	17.01		☑	Five Year Review Issue	☐
24575	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F13	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	11.00	11.00		☑	Five Year Review Issue	☐
24579	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F12	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	13.00	13.00		☑	Five Year Review Issue	☐
24635	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F14	Feb07	05	AAOS, ASES, ASSH, OTA	10.00	10.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
24665	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F15	Feb07	05	AAOS, ASES, ASSH, OTA	8.22	8.22	Yes	☑	Five Year Review Issue - Referred to CPT	☐
24666	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F16	Feb07	05	AAOS, ASES, ASSH, OTA	9.74	9.74	Yes	☑	Five Year Review Issue - Referred to CPT	☐
24670	090	R	Feb07	29	Coronoid Fracture		Editorial			2.60	2.60	Yes	☑		☐
24675	090	R	Feb07	29	Coronoid Fracture		Editorial			4.79	4.79	Yes	☑		☐
24685	090	R	Feb07	29	Coronoid Fracture		Editorial			8.92	8.92	Yes	☑		☐
24685	090	R	Oct06	07	Internal or External Fixation - Elbow/Hnad	F17	Feb07	05	AAOS, ASES, ASSH, OTA	9.50	9.50		☑	Five Year Review Issue	☐
25515	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F18	Feb07	05	AAOS, ASES, ASSH, OTA	10.00	10.00		☑	Five Year Review Issue	☐
25525	090	R	Feb07	10	Internal or External Fixation		Editorial			12.69	12.69	Yes	☑	Five Year Review Issue	☐
25525	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F19	Feb07	05	AAOS, ASES, ASSH, OTA	12.00	12.00		☑	Five Year Review Issue	☐
25526	090	R	Feb07	10	Internal or External Fixation		Editorial			13.43	13.43	Yes	☑	Five Year Review Issue	☐
25526	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F20	Feb07	05	AAOS, ASES, ASSH, OTA	15.00	15.00		☑	Five Year Review Issue	☐
25545	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F21	Feb07	05	AAOS, ASES, ASSH, OTA	9.00	9.00		☑	Five Year Review Issue	☐
25574	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F22	Feb07	05	AAOS, ASES, ASSH, OTA	10.00	10.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
25575	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F23	Feb07	05	AAOS, ASES, ASSH, OTA	14.00	14.00		☑	Five Year Review Issue	☐
25620	090	D	Oct06	07	Internal or External Fixation - Elbow/Hand		Feb07	05	AAOS, ASES, ASSH, OTA				☑	Five Year Review Issue	☐
25628	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F24	Feb07	05	AAOS, ASES, ASSH, OTA	11.00	11.00		☑	Five Year Review Issue	☐
26615	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F25	Feb07	05	AAOS, ASES, ASSH, OTA	8.00	8.00		☑	Five Year Review Issue	☐
26650	090	R	Feb07	10	Internal or External Fixation		Editorial			5.80	5.80	Yes	☑	Five Year Review Issue	☐
26650	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F26	Feb07	05	AAOS, ASES, ASSH, OTA	6.00	6.00		☑	Five Year Review Issue	☐
26665	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F27	Feb07	05	AAOS, ASES, ASSH, OTA	9.00	9.00		☑	Five Year Review Issue	☐
26685	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F28	Feb07	05	AAOS, ASES, ASSH, OTA	8.00	8.00		☑	Five Year Review Issue	☐
26715	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F29	Feb07	05	AAOS, ASES, ASSH, OTA	7.95	7.95		☑	Five Year Review Issue	☐
26735	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F30	Feb07	05	AAOS, ASES, ASSH, OTA	8.40	8.40		☑	Five Year Review Issue	☐
26746	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F31	Feb07	05	AAOS, ASES, ASSH, OTA	11.10	11.10		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
26765	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F32	Feb07	05	AAOS, ASES, ASSH, OTA	6.60	6.60		☑	Five Year Review Issue	☐
26785	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F33	Feb07	05	AAOS, ASES, ASSH, OTA	7.45	7.45		☑	Five Year Review Issue	☐
27248	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F34	Apr07	12	AAOS, AAHKS, OTA	12.83	12.83		☑	Five Year Review Issue	☐
27267	090	N	Feb07	33	Femoral Head Fracture Treatment	W1	Apr07	11	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☐
27268	090	N	Feb07	33	Femoral Head Fracture Treatment	W2	Apr07	11	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☐
27269	090	N	Feb07	33	Femoral Head Fracture Treatment	W3	Apr07	11	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☐
27416	090	N	Feb07	34	Open Knee Osteochondral Autograft	X1	Apr07	13	AAOS	14.00	14.00		☑		☐
27511	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F35	Apr07	12	AAOS, AAHKS, OTA	18.05	18.05		☑	Five Year Review Issue	☐
27513	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F36	Apr07	12	AAOS, AAHKS, OTA	23.04	23.04		☑	Five Year Review Issue	☐
27514	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F37	Apr07	12	AAOS, AAHKS, OTA	17.43	17.43		☑	Five Year Review Issue	☐
27519	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F38	Apr07	12	AAOS, AAHKS, OTA	15.80	15.80	Yes	☑	Five Year Review Issue	☐
27535	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F39	Apr07	12	AAOS, AAHKS, OTA	16.00	16.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
27540	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F40	Apr07	12	AAOS, AAHKS, OTA	13.45	13.45	Yes	☑	Five Year Review Issue	☐
27556	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F41	Apr07	12	AAOS, AAHKS, OTA	15.50	15.50		☑	Five Year Review Issue	☐
27557	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F42	Apr07	12	AAOS, AAHKS, OTA	19.00	19.00		☑	Five Year Review Issue	☐
27558	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F43	Apr07	12	AAOS, AAHKS, OTA	22.00	22.00		☑	Five Year Review Issue	☐
27726	090	N	Feb07	35	Fibula Malunion	Z1	Apr07	15	AAOS, AOFAS	14.20	14.20		☑		☐
27766	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F44	Feb07	06	AAOS, AOFAS, APMA, OTA	8.50	8.50		☑	Five Year Review Issue	☐
27767	090	N	Feb07	36	Posterior Malleolar Fracture Treatment	Y1	Apr07	14	AAOS, AOFAS	2.50	2.50		☑		☐
27768	090	N	Feb07	36	Posterior Malleolar Fracture Treatment	Y2	Apr07	14	AAOS, AOFAS	5.00	5.00		☑		☐
27769	090	N	Feb07	36	Posterior Malleolar Fracture Treatment	Y3	Apr07	14	AAOS, AOFAS	10.00	10.00		☑		☐
27784	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F45	Feb07	06	AAOS, AOFAS, APMA, OTA	10.45	10.45		☑	Five Year Review Issue	☐
27792	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F46	Feb07	06	AAOS, AOFAS, APMA, OTA	10.50	10.50		☑	Five Year Review Issue	☐
27808	090	R	Feb07	37	Bimalleolar Ankle Fracture		Editorial			2.91	2.91	Yes	☑		☐
27810	090	R	Feb07	37	Bimalleolar Ankle Fracture		Editorial			5.20	5.20	Yes	☑		☐
27814	090	R	Feb07	37	Bimalleolar Ankle Fracture		Editorial			11.10	11.10	Yes	☑		☐
27814	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F47	Feb07	06	AAOS, AOFAS, APMA, OTA	14.20	11.50		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
27822	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F48	Feb07	06	AAOS, AOFAS, APMA, OTA	14.75	12.12	Yes	☑	Five Year Review Issue	☐
27823	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F49	Feb07	06	AAOS, AOFAS, APMA, OTA	15.00	14.26	Yes	☑	Five Year Review Issue	☐
27826	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F50	Feb07	06	AAOS, AOFAS, APMA, OTA	14.00	12.00		☑	Five Year Review Issue	☐
27827	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F51	Feb07	06	AAOS, AOFAS, APMA, OTA	20.00	16.00		☑	Five Year Review Issue	☐
27828	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F52	Feb07	06	AAOS, AOFAS, APMA, OTA	24.00	20.00		☑	Five Year Review Issue	☐
27829	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F53	Feb07	06	AAOS, AOFAS, APMA, OTA	9.50	9.50		☑	Five Year Review Issue	☐
27832	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F54	Feb07	06	AAOS, AOFAS, APMA, OTA	11.00	11.00		☑	Five Year Review Issue	☐
28415	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F55	Feb07	06	AAOS, AOFAS, APMA, OTA	20.06	17.54	Yes	☑	Five Year Review Issue	☐
28420	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F56	Feb07	06	AAOS, AOFAS, APMA, OTA	23.50	19.00		☑	Five Year Review Issue	☐
28445	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F57	Feb07	06	AAOS, AOFAS, APMA, OTA	21.50	17.07	Yes	☑	Five Year Review Issue	☐
28446	090	N	Feb07	38	Open Osteochondral Talus Graft	AA1	Apr07	16	AAOS, APMA, AOFAS	17.50	17.50		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
28465	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F58	Feb07	06	AAOS, AOFAS, APMA, OTA	10.50	9.50		☑	Five Year Review Issue	☐
28485	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F59	Feb07	06	AAOS, AOFAS, APMA, OTA	8.00	8.00		☑	Five Year Review Issue	☐
28505	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F60	Feb07	06	AAOS, AOFAS, APMA, OTA	8.30	8.00		☑	Five Year Review Issue	☐
28525	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F61	Feb07	06	AAOS, AOFAS, APMA, OTA	6.00	6.00		☑	Five Year Review Issue	☐
28555	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F62	Feb07	06	AAOS, AOFAS, APMA, OTA	10.43	10.43		☑	Five Year Review Issue	☐
28585	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F63	Feb07	06	AAOS, AOFAS, APMA, OTA	12.00	12.00		☑	Five Year Review Issue	☐
28615	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F64	Feb07	06	AAOS, AOFAS, APMA, OTA	11.50	11.50		☑	Five Year Review Issue	☐
28645	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F65	Feb07	06	AAOS, AOFAS, APMA, OTA	8.00	8.00		☑	Five Year Review Issue	☐
28675	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F66	Feb07	06	AAOS, AOFAS, APMA, OTA	6.00	6.00		☑	Five Year Review Issue	☐
29828	090	N	Feb07	39	Arthroscopic Biceps Tendesis	BB1	Apr07	17	AAOS	13.00	13.00		☑		☑
29855	090	R	Feb07	10	Internal or External Fixation		Editorial			10.60	10.60	Yes	☑	Five Year Review Issue	☐
29856	090	R	Feb07	10	Internal or External Fixation		Editorial			14.12	14.12	Yes	☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
29904	090	N	Feb07	30	Subtalar Arthroscopy	CC1	Apr07	18	AAOS, APMA, AOFAS	8.50	8.50		☑		☐
29905	090	N	Feb07	30	Subtalar Arthroscopy	CC2	Apr07	18	AAOS, APMA, AOFAS	9.00	9.00		☑		☐
29906	090	N	Feb07	30	Subtalar Arthroscopy	CC3	Apr07	18	AAOS, APMA, AOFAS	9.47	9.47		☑		☐
29907	090	N	Feb07	30	Subtalar Arthroscopy	CC4	Apr07	18	AAOS, APMA, AOFAS	12.00	12.00		☑		☐
31500	000	R	Feb07	05	Insert Emergency Airway	DD2	Apr07	20	ASA, ACEP	2.55	2.33	Yes	☑	Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
33257	ZZZ	N	Feb07	41	Add-On Maze Procedures	EE1	Apr07	23	STS	9.63	9.63		☑		☑
33258	ZZZ	N	Feb07	41	Add-On Maze Procedures	EE2	Apr07	23	STS	11.00	11.00		☑		☑
33259	ZZZ	N	Feb07	41	Add-on Maze Procedures	EE3	Apr07	23	STS	14.14	14.14		☑		☑
33517	ZZZ	R	Feb07	05	Modifier -51		Editorial			3.61	3.61	Yes	☑		☐
33518	ZZZ	R	Feb07	05	Modifier -51		Editorial			7.93	7.93	Yes	☑		☐
33519	ZZZ	R	Feb07	05	Modifier -51		Editorial			10.49	10.49	Yes	☑		☐
33521	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.59	12.59	Yes	☑		☐
33522	ZZZ	R	Feb07	05	Modifier -51		Editorial			14.14	14.14	Yes	☑		☐
33523	ZZZ	R	Feb07	05	Modifier -51		Editorial			16.08	16.08	Yes	☑		☐
33861	090	R	Feb07	42	Valve Sparing Aortic Annulus Reconstruction	FF1	Apr07	24	STS	43.94	43.94	Yes	☑		☐
33863	090	R	Feb07	42	Valve Sparing Aortic Annulus Reconstruction	FF2	Apr07	24	STS	58.71	58.71	Yes	☑		☐
33864	090	N	Feb07	42	Valve Sparing Aortic Annulus Reconstruction	FF3	Apr07	24	STS	60.00	60.00		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
34806	ZZZ	N	Feb07	96	Wireless Pressue Sensor Implantation and Study	GG1	Apr07	25	SVS, SIR, ACR	2.06	2.06		☑		☑
35523	090	N	Feb07	43	Brachial-Ulnar Bypass Graft	HH1	Apr07	26	SVS	24.00	24.00		☑		☐
35600	ZZZ	R	Feb07	05	Modifier -51		Editorial			30.15	30.15	Yes	☑		☐
36540	XXX	D	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO				☑		☐
36550	XXX	D	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO				☑		☐
36591	XXX	N	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO	0.00	0.00		☑	Practice Expense Inputs Only, Renumbered Code from 36540	☐
36592	XXX	N	Jun06	11	Non-implantable Venous Access Device Blood Draws	B1	Oct06	08	ASCO	0.00	0.00		☑	Practice Expense Inputs Only	☐
36593	XXX	N	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO	0.00	0.00		☑	Practice Expense Inputs Only, Renumbered Code from 36550	☐
36620	000	R	Feb07	05	Arterial Catheterization	DD3	Apr07	21	ASA	1.50	1.15	Yes	☑	Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
36838	090	R	Feb07	43	Brachial-Ulnar Bypass Graft		Apr07	26	SVS	21.59	21.59	Yes	☑		☐
41019	000	N	Feb07	46	Head and Neck Interstitial Brachytherapy Needle or Catheter Placement	II1	Apr07	27	ASTRO	11.00	8.84		☑		☐
43246	000	R	Feb07	50	G-, J-, G-J, C-Tube Procedures		Apr07	29		4.32	4.32	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43750	010	D	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK10	Apr07	29	SIR, ACR, ACS				☑		☐
43760	000	R	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK11	Apr07	29	SIR, ACR, AGA, ASGE	1.10	0.90		☑	Interim Value - September 07 RUC	☐
43770	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			17.85	17.85	Yes	☑		☐
43771	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			20.64	20.64	Yes	☑		☐
43772	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			15.62	15.62	Yes	☑		☐
43773	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			20.64	20.61	Yes	☑		☐
43774	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			15.66	15.66	Yes	☑		☐
47719	090	D	Feb07	48	Choledochal Cyst Anastomosis		Deleted						☑		☐
49200	090	D	Feb07	49	Peritoneal Tumor Ablation		Apr07	28	ACS				☑		☐
49201	090	D	Feb07	49	Peritoneal Tumor Ablation		Apr07	28	ACS				☑		☐
49203	090	N	Feb07	49	Peritoneal Tumor Ablation	JJ1	Apr07	28	ACS, ACOG	19.69	20.00		☑		☐
49204	090	N	Feb07	49	Peritoneal Tumor Ablation	JJ2	Apr07	28	ACS, ACOG	26.00	26.00		☑		☐
49205	090	N	Feb07	49	Peritoneal Tumor Ablation	JJ3	Apr07	28	ACS	30.00	30.00		☑		☐
49441	010	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK1	Apr07	29	SIR, ACR	4.60	3.32		☑	Interim Value - September 07 RUC	☐
49441	010	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK2	Apr07	29	SIR, ACR	7.00	5.72		☑	Interim Value - September 07 RUC	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
49442	010	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK3	Apr07	29	SIR, ACR	6.58	3.87		☑	Interim Value - September 07 RUC	☐
49446	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK4	Apr07	29	SIR, ACR	3.50	2.94		☑	Interim Value - September 07 RUC	☐
49450	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK5	Apr07	29	SIR, ACR	1.50	1.14		☑	Interim Value - September 07 RUC	☐
49451	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK6	Apr07	29	SIR, ACR	2.20	1.82		☑	Interim Value - September 07 RUC	☐
49452	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK7	Apr07	29	SIR, ACR	3.30	2.81		☑	Interim Value - September 07 RUC	☐
49460	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK8	Apr07	29	SIR, ACR	2.00	1.51		☑	Interim Value - September 07 RUC	☐
49465	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK9	Apr07	29	SIR, ACR	0.76	0.62		☑	Interim Value - September 07 RUC	☐
49568	ZZZ	R	Oct06	05	Mesh Implantation		Editorial			5.00	5.00	Yes	☑		☐
50385	000	N	Oct06	13	Transuretheral Ureteral Stent Tube Exchange and Removal	G1	Feb07	07	ACR, SIR	4.44	4.44		☑		☐
50386	000	N	Oct06	13	Transuretheral Ureteral Stent Tube Exchange and Removal	G2	Feb07	07	ACR, SIR	3.30	3.30		☑		☐
50593	010	N	Feb07	97	Percutaneous Renal Tumor Cryotherapy	MM1	Apr07	A	AUA, SIR, ACR	13.00	9.08		☑		☑
51797	ZZZ	R	Oct06	14	Intra-Abdominal Voiding Pressure	H1	Apr07	30	AUA	0.80	0.80		☑	Global period change	☐

CPT Code	Global Period	ding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	R Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Commen	New Tech/Service
52510	090	D	Feb07	51	Transuretheral Balloon Dilation of the Prostatic Urethra		Deleted						☑		☐
52601	090	R	Feb07	52	Prostate Laser Enucleation		Apr07	B	AUA	15.13	15.13	Yes	☑		☐
52647	090	R	Feb07	52	Prostate Laser Enucleation	NN1	Apr07	B	AUA	11.15	11.15	Yes	☑		☐
52648	090	R	Feb07	52	Prostate Laser Enucleation	NN2	Apr07	B	AUA	12.00	12.00	Yes	☑		☐
52649	090	N	Feb07	52	Prostate Laser Enucleation	NN3	Apr07	B	AUA	17.16	17.16		☑		☐
55920	000	N	Feb07	56	Pelvic Interstitial Brachytherapy Needle or Catheter Placement	LL1	Apr07	31	ASTRO	10.50	8.31		☑		☐
57284	090	R	Feb07	31	Laparaoscopic Paravaginal Defect Repair	OO1	Apr07	C	ACOG	14.25	14.25		☑		☐
57285	090	N	Feb07	31	Laparaoscopic Paravaginal Defect Repair	OO2	Apr07	C	ACOG	11.52	11.52		☑		☐
57423	090	N	Feb07	31	Laparaoscopic Paravaginal Defect Repair	OO3	Apr07	C	ACOG	16.00	16.00		☑		☑
57500	000	R	Feb07	53	Biopsy of Cervix		Editorial			1.20	1.20	Yes	☑		☐
58550	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP5	Apr07	D	ACOG	14.97	14.97	Yes	☑		☐
58552	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP6	Apr07	D	ACOG	16.78	16.78	Yes	☑		☐
58553	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP7	Apr07	D	ACOG	19.96	19.96	Yes	☑		☐
58554	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP8	Apr07	D	ACOG	22.98	22.98	Yes	☑		☐
58570	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP1	Apr07	D	ACOG	15.75	15.75		☑		☑
58571	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP2	Apr07	D	ACOG	17.56	17.56		☑		☑
58572	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP3	Apr07	D	ACOG	19.96	19.96		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
58573	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP4	Apr07	D	ACOG	22.98	22.98		☑		☑
67038	090	D	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping		Feb07	09	AAO				☑	Five Year Review Issue	☐
67041	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I1	Feb07	09	AAO	19.00	19.00		☑	Five Year Review Issue	☐
67042	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I2	Feb07	09	AAO	22.13	22.13		☑	Five Year Review Issue	☐
67043	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I3	Feb07	09	AAO	22.94	22.94		☑	Five Year Review Issue	☐
67108	090	R	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I4	Feb07	09	AAO	22.49	22.49	Yes	☑	Five Year Review Issue	☐
67113	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I5	Feb07	09	AAO	25.00	25.00		☑	Five Year Review Issue	☐
67227	090	R	Oct06	20	Retinopathy Treatment		Feb07	10	AAO	7.38	7.38	Yes	☑	Five Year Review Issue	☐
67228	090	R	Oct06	20	Retinopathy Treatment	J1	Feb07	10	AAO	13.67	13.67	Yes	☑	Five Year Review Issue	☐
67229	090	N	Oct06	20	Retinopathy Treatment	J2	Feb07	10	AAO	16.00	16.00		☑	Five Year Review Issue	☐
68816	010	N	Feb07	57	Nasolacrimal Duct Balloon Catheter Dilation	QQ1	Apr07	E	AAO	3.00	3.00		☑		☑
70496	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.75	1.75	Yes	☑		☐
70498	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.75	1.75	Yes	☑		☐
71275	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.92	1.92	Yes	☑		☐
72191	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.81	1.81	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
73206	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.81	1.81	Yes	☑		☐
73706	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.90	1.90	Yes	☑		☐
74175	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.90	1.90	Yes	☑		☐
74350	XXX	D	Feb07	50	G-, J-, G-J, C-Tube Procedures		Apr07	29					☑		☐
75552	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75553	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75554	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75555	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75556	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75557	XXX	N	Feb07	13	Cardiac MRI	RR1	Apr07	F	ACR, ACC	2.35	2.35		☑	Five Year Review Issue	☑
75558	XXX	N	Feb07	13	Cardiac MRI	RR2	Apr07	F	ACR, ACC	2.60	2.60		☑	Five Year Review Issue	☑
75559	XXX	N	Feb07	13	Cardiac MRI	RR3	Apr07	F	ACR, ACC	2.95	2.95		☑	Five Year Review Issue	☑
75560	XXX	N	Feb07	13	Cardiac MRI	RR4	Apr07	F	ACR, ACC	3.00	3.00		☑	Five Year Review Issue	☑
75561	XXX	N	Feb07	13	Cardiac MRI	RR5	Apr07	F	ACR, ACC	2.60	2.60		☑	Five Year Review Issue	☑
75562	XXX	N	Feb07	13	Cardiac MRI	RR6	Apr07	F	ACR, ACC	2.86	2.86		☑	Five Year Review Issue	☑
75563	XXX	N	Feb07	13	Cardiac MRI	RR7	Apr07	F	ACR, ACC	3.00	3.00		☑	Five Year Review Issue	☑
75564	XXX	N	Feb07	13	Cardiac MRI	RR8	Apr07	F	ACR, ACC	3.35	3.35		☑	Five Year Review Issue	☑
75635	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			2.40	2.40	Yes	☑		☐

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75984	XXX	R	Feb07	50	G-, J-, G-J, C-Tube Procedures		Apr07	29		0.72	0.72	Yes	☑		☐
76376	XXX	R	Jun06	40	Computer Aided Detection and Algorithm Analysis of Breast MRI		Editorial			0.20	0.20	Yes	☑		☐
76377	XXX	R	Jun06	40	Computer Aided Detection and Algorithm Analysis of Breast MRI		Editorial			0.79	0.79	Yes	☑		☐
77371	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			0.00	0.00	Yes	☑		☐
77372	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			0.00	0.00	Yes	☑		☐
77432	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			7.92	7.92	Yes	☑		☐
77435	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			13.00	13.00	Yes	☑		☐
78600	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K1	Editorial		SNM, ACR	0.44	0.44	Yes	☑	PE Recommendations Only	☐
78601	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K2	Editorial		SNM, ACR	0.51	0.51	Yes	☑	PE Recommendations Only	☐
78605	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K3	Editorial		SNM, ACR	0.53	0.53	Yes	☑	PE Recommendations Only	☐
78606	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K4	Editorial		SNM, ACR	0.64	0.64	Yes	☑	PE Recommendations Only	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
78607	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K5	Editorial		SNM, ACR	1.23	1.23	Yes	☑	PE Recommendations Only	☐
78615	XXX	D	Oct06	23	Brain and Cerebrospinal Fluid Imaging		Deleted		SNM, ACR				☑		☐
78811	XXX	R	Feb07	58	PET Imaging	YY1	Apr07	G	SNM, ACR	1.54	1.54	Yes	☑		☑
78812	XXX	R	Feb07	58	PET Imaging	YY2	Apr07	G	SNM, ACR	1.93	1.93	Yes	☑		☑
78813	XXX	R	Feb07	58	PET Imaging	YY3	Apr07	G	SNM, ACR	2.00	2.00	Yes	☑		☑
78814	XXX	R	Feb07	58	PET Imaging	YY4	Apr07	G	SNM, ACR	2.20	2.20	Yes	☑		☑
78815	XXX	R	Feb07	58	PET Imaging	YY5	Apr07	G	SNM, ACR	2.44	2.44	Yes	☑		☑
78816	XXX	R	Feb07	58	PET Imaging	YY6	Apr07	G	SNM, ACR	2.50	2.50	Yes	☑		☑
80047	XXX	N	Feb07	102	Basic Metabolic Panel		CLFS						☐		☐
80048	XXX	R	Feb07	102	Basic Metabolic Panel		CLFS						☐		☐
82272	XXX	R	Oct06	29	Diagnositc Occult Blood Test		CLFS						☐		☐
82610	XXX	N	Feb07	62	Cystatin C		CLFS						☐		☐
83021	XXX	R	Feb07	63	Ion Exchange HPLC Glycosylated Hemoglobin Test		CLFS						☐		☐
83036	XXX	R	Feb07	63	Ion Exchange HPLC Glycosylated Hemoglobin Test		CLFS						☐		☐
83656	XXX	N	Feb07	69	Unlisted Antigen		CLFS						☐		☐
83898	XXX	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83900	XXX	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83901	ZZZ	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83908	XXX	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83993	XXX	N	Feb07	67	Calprotectin		CLFS						☐		☐

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84704	XXX	N	Feb07	65	Human Free Chorionic Gonadotropin		CLFS						☐		☐
86486	XXX	N	Feb07	69	Unlisted Antigen		CLFS						☐		☐
86586	XXX	D	Feb07	69	Unlisted Antigen		Deleted						☐		☐
86885	XXX	R	Oct06	51	Antibody Screening - Indirect Antiglobulin Test Tube		CLFS						☐		☐
86886	XXX	R	Oct06	51	Antibody Screening - Indirect Antiglobulin Test Tube		CLFS						☐		☐
87500	XXX	N	Feb07	72	Nucleic Acid Vancomycin Resistant Enterococcus Species Detection		CLFS						☐		☐
87809	XXX	N	Feb07	71	Adenoviral Conjunctivitis Detection		CLFS						☐		☐
88380	XXX	R	Oct06	26	Manual Microdisection	L2	Feb07	12	CAP	1.56	1.56		☑		☑
88381	XXX	N	Oct06	26	Manual Microdisection	L1	Feb07	12	CAP	1.18	1.18		☑		☑
89320	XXX	R	Oct06	28	Complete Semen Analysis with Morphology Assessment		CLFS						☐		☐
89321	XXX	R	Oct06	28	Complete Semen Analysis with Morphology Assessment		CLFS						☐		☐
89322	XXX	N	Oct06	28	Complete Semen Analysis with Morphology Assessment		CLFS						☐		☐
89331	XXX	N	Oct06	27	Retrograde Ejaculation Analysis		CLFS						☐		☐
90284	XXX	N	Feb07	80	Immune Globulin Subcutaneous Infusion		CLFS						☐		☐

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90661	XXX	N	Feb07	76	Cultured Derived Influenza Vaccine		CLFS						☐		☐
90662	XXX	N	Feb07	78	High Dose Intramuscular Influenza Vaccine		CLFS						☐		☐
90663	XXX	N	Feb07	78	Pandemic Influenza Virus Vaccine		CLFS						☐		☐
90761	ZZZ	R	Feb07	81	Facility Therapeutic Infusions		Editorial			0.09	0.09	Yes	☑		☐
90766	ZZZ	R	Oct06	09	Drug Administration Procedures Clarification		Editorial			0.18	0.18	Yes	☑		☐
90769	XXX	N	Feb07	80	Immune Globulin Subcutaneous Infusion	SS1	Apr07	H	JCAAI	0.25	0.21		☑		☑
90770	ZZZ	N	Feb07	80	Immune Globulin Subcutaneous Infusion	SS2	Apr07	H	JCAAI	0.19	0.18		☑		☑
90771	ZZZ	N	Feb07	80	Immune Globulin Subcutaneous Infusion	SS3	Apr07	H	JCAAI	0.21	0.00		☑	Practice Expense Inputs Only	☑
90776	ZZZ	N	Feb07	81	Facility Therapeutic Infusions		No MFS						☐	Not Payable on Physician Fee Schedule	☐
93503	000	R	Feb07	05	Insertion and Placement of Heart Catheter	DD4	Apr07	22	ASA	2.91	2.91	Yes	☑	Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
93539	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			0.40	0.40	Yes	☑		☐
93545	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			0.40	0.40	Yes	☑		☐
93555	XXX	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐

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93556	XXX	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐
93561	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐
93562	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐
93982	XXX	N	Feb07	96	Wireless Pressue Sensor Implantation and Study	GG2	Apr07	25	SVS, SIR, ACR	0.30	0.30		☑		☑
95004	XXX	R	Feb06	93	Allergy Test Interpretation		Feb07	21	JCAAI, AAOA	0.01	0.01		☑	Five Year Review Issue	☐
95024	XXX	R	Feb06	93	Allergy Test Interpretation		Feb07	21	JCAAI, AAOA	0.01	0.01		☑	Five Year Review Issue	☐
95027	XXX	R	Feb06	93	Allergy Test Interpretation		Feb07	21	JCAAI, AAOA	0.01	0.01		☑	Five Year Review Issue	☐
95980	XXX	N	Oct06	38	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	M1	Apr07	I	AGA, ASGE, ACG, AMS	0.80	0.80	Yes	☑		☑
95981	XXX	N	Oct06	38	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	M2	Apr07	I	AGA, ASGE, ACG, AMS	0.30	0.30	Yes	☑		☑
95982	XXX	N	Oct06	38	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	M3	Apr07	I	AGA, ASGE, ACG, AMS	0.65	0.65	Yes	☑		☑
96101	XXX	R	Feb07	101	Psychological Neuropsychological Testing Codes		Editorial			1.86	1.86	Yes	☑		☐

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96118	XXX	R	Feb07	101	Psychological Neuropsychological Testing Codes		Editorial			1.86	1.86	Yes	☑		☐
96415	ZZZ	R	Oct06	09	Drug Administration Procedures Clarification		Editorial			0.19	0.19	Yes	☑		☐
96423	ZZZ	R	Oct06	09	Drug Administration Procedures Clarification		Editorial			0.17	0.17	Yes	☑		☐
96523	XXX	R	Jun06	27	Implanted Venous Access Device Irrigation		Editorial			0.04	0.04	Yes	☑		☐
99174	XXX	N	Feb07	92	Ocular Photoscreening	UU1	Apr07	J					☑	No RUC Recommendation	☐
99361	XXX	D	Jun06	06	Team Conference - RUC		Apr07	K	AGS				☑		☐
99362	XXX	D	Jun06	06	Team Conference - RUC		Apr07	K	AGS				☑		☐
99367	XXX	N	Jun06	06	Team Conference - RUC	C3	Apr07	K	AGS	1.10	1.10		☑		☐
99371	XXX	D	Oct06	06	Non-Face to Face Physician - RUC		Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				☑		☐
99372	XXX	D	Oct06	06	Non-Face to Face Physician - RUC		Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				☑		☐
99373	XXX	D	Oct06	06	Non-Face to Face Physician - RUC		Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				☑		☐
99406	XXX	N	Feb07	19	Smoking Cessation	VV1	Apr07	L	ACCP/ATS, ACP	0.24	0.24		☑		☐
99407	XXX	N	Feb07	19	Smoking Cessation	VV2	Apr07	L	ACCP/ATS, ACP	0.50	0.50		☑		☐
99408	XXX	N	Feb07	14	Alcohol, Drug Screening and Brief Intervention	WW1	Apr07	M	APA, AAFP, ACP	0.65	0.65		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99409	XXX	N	Feb07	14	Alcohol, Drug Screening and Brief Intervention	WW2	Apr07	M	APA, AAFP, ACP	1.30	1.30		☑		☐
99441	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O1	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	0.35	0.25		☑		☑
99442	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O2	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	0.60	0.50		☑		☑
99443	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O3	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	0.92	0.75		☑		☑
99444	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O4	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	Carrier Priced	Carrier Priced		☑		☐
99477	XXX	N	Oct06	30	Initial Day Hospital Neonate Care	N1	Feb07	14	AAP	7.00	7.00		☑		☐
99605	XXX	N	Feb07	94	Medication Therapy Management Services		No MFS						☐	No Medicare Physician Payment Schedule Benefit for Pharmacist Services	☐
99606	XXX	N	Feb07	94	Medication Therapy Management Services		No MFS						☐	No Medicare Physician Payment Schedule Benefit for Pharmacist Services	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99607	ZZZ	N	Feb07	94	Medication Therapy Management Services		No MFS						☐	No Medicare Physician Payment Schedule Benefit for Pharmacist Services	☐

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Anesthesia for Radiologic Spine Procedures

The CPT Editorial Panel created two new codes and deleted one existing code to clearly differentiate between anesthesia care for diagnostic and therapeutic radiological procedures on the spine.

The RUC reviewed the survey data for CPT code 01935 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic.* The RUC agreed with the specialty that CPT code 01992 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position* (Base Unit=5.00) was an excellent reference for this code. Although the intra-service time of the surveyed code was higher than the reference code, 55 minutes and 30 minutes respectively, the intensity/complexity measures for these two procedures demonstrate that these two procedures require very similar intensity and complexity to perform. Therefore, the RUC agreed with the specialty society that the base unit for this procedure should be valued at 5.00 base units, the 25th percentile and median of the survey. **The RUC recommends 5.00 Base Units for 01935.**

The RUC reviewed the survey data for CPT code 01936 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic.* The RUC noted that the reference code 00630 *Anesthesia for procedures in lumbar region; not otherwise specified* (Base Unit=8.00) had significantly more total service time associated with it compared to the surveyed code, 196 minutes and 115 minutes respectively. Conversely, the surveyed code demonstrated slightly higher intensity and complexity measures compared to the reference code. However, because this code is subject to work neutrality policy, the specialty society recommended the 5.00 Base Units for this procedure, which is the 25th percentile of their survey data. The RUC agreed with this rationale for valuation. **The RUC recommends 5.00 Base Units for 01936.**

Practice Expense:
The RUC recommends the anesthesiology practice expense standard of 8 minutes of clinical labor time consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination and completion of forms in the facility setting.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●01935	P1	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	XXX	5.00
●01936	P2	therapeutic	XXX	5.00
D 01905		~~Anesthesia for myelography, discography, vertebroplasty~~ (01905 has been deleted. To report, see 01935 or 01936)	XXX	N/A

2

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01935 Tracking Number: P1Specialty Society Recommended Base Unit Value: 5
Global Period:XXX RUC Recommended Base Unit Value: 5

CPT Descriptor: Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year-old man with an anxiety disorder, chronic pain requiring opioids for control, and severe back and radicular pain secondary to possible herniated discs or arthritis presents for discography of the L3/L4, L4/L5 and L5/S1 disks in the prone position. A previous attempt at discography under moderate sedation was abandoned due to the patient suffering a panic attack during the procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 96.00%

Description of Pre-Service Work:
Obtain a careful medical history, systems review and a physical examination, with emphasis on the cardiopulmonary system and assessment of the airway in anticipation of managing the airway in a patient in the prone position. Note current medication and allergies with special attention to cardiovascular and pain medications, particularly opioids since there can be significant opioid tolerance and dependence in patients on long term opioid therapy.

Counsel the patient regarding anesthesia, including analgesic medications, anesthetic agents, monitoring, the possibility of endotracheal intubation, and possible complications

Prepare anesthesia equipment and drugs.

Review the record and any interim data, reassess the patient and obtain informed consent for anesthesia (including discussion of anesthesia risks)

Description of Intra-Service Work:
Confirm informed consent, start a peripheral intravenous catheter, administer an anxiolytic, and accompany the patient to the radiology suite.

Attach routine monitors (ECG, Pulse Oximetry, NIBP, end-tidal CO2) on the patient, assist in positioning the patient in the prone position on the operating/procedure table, and apply a nasal cannula or face mask to provide supplemental oxygen during the sedation and procedure.

Once the patient is properly positioned for surgery and all areas of concern are addressed, there is final confirmation of patient identification, surgical procedure and antibiotic administration before the procedure begins.

Administer sedation agents to provide comfort and anxiolysis while still maintaining spontaneous ventilation and hemodynamic stability. At points during the procedure the patient must be able to describe whether or not his typical pain is recreated during discography. This requires that the anesthesiologist carefully titrate sedation and analgesia to allow the patient to awaken quickly to a cogent but analgesic state. Analgesia is often a challenge in these patients as they often have opioid tolerance and may have tried to reduce their medications prior to surgery in an attempt to reveal their pain syndrome more effectively.

At the end of the procedure, the anesthesiologist assists in turning the patient supine and transferring him to the post anesthetic care unit where he will be cared for by the recovery room nursing staff until discharge.

Description of Post-Service Work:
Order appropriate analgesia/antiemetic as needed for post procedure discomfort.

Dispose of anesthesia equipment and drugs consistent with JCAHO standards.

Make a postoperative evaluation in the post anesthesia care unit to determine satisfactory recovery from anesthetic care and determine if any anesthetic related complications have occurred.

Discharge patient from the unit.

Make a post-PACU visit to inquire about any adverse sequelae.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Tripti Kataria, MD, MPH				
Specialty(s):	American Society of Anesthesiologists				
CPT Code:	01935				
Sample Size: 250	**Resp n:** 28	**Resp %:** 11.2%			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**3.00**	10.00	20.00
Survey Base Unit Values:	3.00	5.00	**5.00**	7.00	12.00
Pre-Anesthesia Time:	**5.00**	**15.00**	**20.00**	**30.00**	**45.00**
Intra-op Anesthesia Time:	30.00	30.00	**55.00**	60.00	130.00
Post-Anesthesia Time:			**15.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than following table.

CPT Code: 01935	
	Specialty Recommended
Base Unit Value:	
Pre-Anesthesia Time:	
Intra-op Anesthesia Time:	
Post-Anesthesia Time:	

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01992	XXX	5	RUC Time

CPT Descriptor Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Base Unit Value	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Base Unit Value	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Base Unit Value	Time Source
00630	XXX	8	CMS Time File

CPT Descriptor Anesthesia for procedures in lumbar region; not otherwise specified

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

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

Number of respondents who choose Key Reference Code: 10

TIME ESTIMATES (Median)	New/Revised CPT Code: 01935	Key Reference CPT Code: 01992	Time Source: RUC Time
Median Pre-Service Time	20.00	15.00	
Median Intra-Service Time	55.00	30.00	
Median Post-service Time	15.00	10.00	
Median Total Time	**90.00**	**55.00**	
		Calculate total reference time tab here	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.80	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.20	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.20	3.20
Physical effort required	3.20	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.30
Outcome depends on the skill and judgement of physician	3.30	3.30
Estimated risk of malpractice suit with poor outcome	3.50	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Anesthesia intensity/complexity	2.90	2.80
Intra-Op Anesthesia intensity/complexity	3.30	3.10
Post-Anesthesia intensity/complexity	2.90	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
We agreed with our respondents' choice of 01992 as a reference code. Code 01992 has a base unit value of 5 which is the survey's 25th and median values. The intensity/complexity rankings between the code under review and the reference service were remarkable similar. This validates our recommended base unit value.

This code, along with 01936 – Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic – was previously reported with code 01905 – Anesthesia for myelography, discography, vertebroplasty. Code 01905, which carried a base unit value of 5, has been deleted and replaced with this pair of codes because the anesthesia work involved differs depending on the type of spine procedure being performed and also on the typical patient undergoing the specific procedure. The base value assigned to 01905 is an accurate reflection of the work, skill, intensity and complexity associated with anesthesia for percutaneous imaged guide procedures that are diagnostic in nature.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01905

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

Specialty Anesthesia	How often? Sometimes
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 25000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesia	Frequency 25000	Percentage	100%
Specialty	Frequency	Percentage	
Specialty	Frequency	Percentage	

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
7500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesia	Frequency 7500	Percentage	100.00%
Specialty	Frequency	Percentage	
Specialty	Frequency	Percentage	

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01936 Tracking Number: P2Specialty Society Recommended Base Unit Value: **5**
Global Period:XXX RUC Recommended Base Unit Value: **5**

CPT Descriptor: Anesthesia for percutaneous image guided procedures on the spine and spinal cord; theraeputic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year-old woman presents with severe, presistent back pain and progressive spinal deformity, secondary to osteoporotic vertebral collapse. Radiographic imaging including MRI confirms the recent compression fracture at L3. A bone biopsy and percutaneous vertebral augmentation with fracture reduction using a mechanical device to create a cavity is planned.

Percentage of Survey Respondents who found Vignette to be Typical: 89.00%

Description of Pre-Service Work:
Obtain a thorough medical history.

Perform physical examination with special attention to the patient's co-morbidities, medications and allergies. The physical exam concentrates on cardiac and pulmonary status, especially as it pertains to the potential pulmonary effects due to kyphoscoliosis that can occur in these patients. Range of motion testing is important in this group as there may be quite restricted movement of the neck, upper and lower extremities and the airway due the severity of their arthritis and associated ankylosis of the spine.

Review the pertinent laboratory data, along with ECG, chest radiograph and other tests that may be significant in this patient population.

Discuss the anesthesia care including anxiolysis, analgesia, general anesthesia, intubation and prone positioning with the patient and family.

Prepare anesthesia equipment and drugs.

Review and assess the record and any interim data.

Obtain informed consent for anesthetic management of the patient (including discussion of anesthesia risks).

Description of Intra-Service Work:
Start a peripheral intravenous catheter, administer an anxiolytic, and accompany the patient to the radiology suite. In the radiology suite, the patient usually receives a small amount of sedation during placement of standard monitors (ECG, Pulse Oximetry, NIBP, end-tidal CO2).

Place a mask over the patient's nose and mouth and administer 100% oxygen prior to induction of general anesthesia.

Infuse an intravenous anesthetic agent (propofol, etomidate, or Pentothal) to induce general anesthesia.

Once the patient is anesthetized and controlled ventilation is established, administer a muscle relaxant (rocuronium, vecuronium, succinylcholine) to facilitate placement of the endotracheal tube.

Once confirmation of the endotracheal tube is established by end-tidal CO2 and auscultation of the chest and abdomen,
secure the endotracheal tube,
position an oral temperature probe, and
administer oxygen and inhalational anesthetic agents as necessary to achieve an adequate depth of anesthesia.

When the patient is ready from an anesthetic point of view (hemodynamically stable, adequately ventilated via a secure airway), direct positioning the patient in the prone position. Placing patients in the prone position under general anesthesia always requires special attention to body alignment and appropriate relief/padding of pressure points (elbows, knees, face, eyes, shoulders, neck); however this patient population is an additional risk due to their usual limitation of range of motion caused by osteoporosis and arthritis. A warm air blanket is positioned over the patient avoiding the surgical field to maintain normothermia.

Once the patient is properly positioned for surgery and all areas of concern are addressed, there is final confirmation of patient identification, surgical procedure, and antibiotic administration before the procedure begins.

Closely monitor the patient throughout the procedure (ECG, oximetry, NIBP, temperature) with additional attention regarding the potential hazards associated with the prone position (inadvertent loss of endotracheal tube, potential ventilation difficulties). This group of older patients tends toward hemodynamic instability due to co-morbidities, associated dehydration and longstanding hypertension.

At the end of the procedure,
turn off the anesthetic agents,
reverse the neuromuscular relaxants, and
administer appropriate analgesia to facilitate emergence.

The patient is turned to the supine position and emergence proceeds while the anesthesiologist carefully and repeatedly assesses vital signs, level of consciousness, ventilatory effort, end-tidal CO2, return of muscle strength, and oxygenation status.

Once the patient has adequately satisfied the requirements for extubation, remove the endotracheal tube and continue to assess the airway for adequacy of ventilation, and administer additional oxygen through a face mask or nasal cannula.

Transfer the patient to the PACU for further recovery and give report to PACU nurse.

Description of Post-Service Work:
Write appropriate orders for analgesia and antiemetis to ensure patient comfort and safety.

Dispose of anesthesia equipment and drugs consistent with JCAHO standards.

Make a postoperative evaluation in the post anesthesia care unit to determine satisfactory recovery from anesthetic care and determine if any anesthetic related complications have occurred.

Discharge the patient from the unit.

Make a post-PACU visit to inquire about any adverse sequelae.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Tripti Kataria, MD, MPH				
Specialty(s):	American Society of Anesthesiologists				
CPT Code:	01936				
Sample Size: 250	**Resp n:** 29	**Resp %:** 11.6%			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	1.00	**5.00**	10.00	25.00
Survey Base Unit Values:	4.00	5.00	**7.00**	8.00	12.00
Pre-Anesthesia Time:	**5.00**	**15.00**	**30.00**	**30.00**	**50.00**
Intra-op Anesthesia Time:	30.00	60.00	**70.00**	120.00	190.00
Post-Anesthesia Time:			**15.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than following table.

CPT Code: 01936	
	Specialty Recommended
Base Unit Value:	**5.00**
Pre-Anesthesia Time:	**30.00**
Intra-op Anesthesia Time:	**70.00**
Post-Anesthesia Time:	**15.00**

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00630	XXX	8	CMS Time File

CPT Descriptor Anesthesia for procedures in lumbar region; not otherwise specified

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Base Unit Value	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Base Unit Value	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Base Unit Value	Time Source
01992	XXX	5	RUC Time

CPT Descriptor Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position

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

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

Number of respondents who choose Key Reference Code: 10

TIME ESTIMATES (Median)	New/Revised CPT Code: 01936	Key Reference CPT Code: 00630	Time Source: CMS Time File
Median Pre-Service Time	30.00	0.00	
Median Intra-Service Time	70.00	0.00	
Median Post-service Time	15.00	0.00	
Median Total Time	**115.00**	**196.00**	
		Calculate total reference time tab here	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.60
Urgency of medical decision making	3.20	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.40
Physical effort required	3.70	3.70

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.70	3.60
Outcome depends on the skill and judgement of physician	3.50	3.40
Estimated risk of malpractice suit with poor outcome	3.60	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Anesthesia intensity/complexity	3.40	3.00
Intra-Op Anesthesia intensity/complexity	3.80	3.60
Post-Anesthesia intensity/complexity	3.20	3.10

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has us IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Recommendations for the appropriate formula and format.*
We agree with our respondents that the base unit value for 01936 should be less than the value assigned to the reference service of 00630 (8 base units). We acknowledge that our respondents' complexity/intensity measures are slightly higher for 01936 than 00630 but none the less, we are recommending 6 base units for code 01936; a value that falls between the 25th and median survey values.

This code, along with 01935 – Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic – was previously reported with code 01905 – Anesthesia for myelography, discography, vertebroplasty. Code 01905, which carried a base unit value of 5, has been deleted and replaced with this pair of codes because the anesthesia work involved differs depending on the type of spine procedure being performed and also on the typical patient undergoing the specific procedure.

With the recent approval of new codes for therapeutic percutaneous procedures on the spine, such as vertebral augmentation, anesthesiologists are seeing a new group of patients for new procedures. The procedures are more painful and typically require general anesthesia. The patients tend to be elderly and more complex medically.

There is a higher level of intensity involved in anesthesia for the therapeutic procedures because we anticipate that both the anesthesia and the procedure cause hemodynamic instability in these patients. That is not the case in the anesthesia for diagnostic procedures as will be reported with code 01935. Specifically, in the cases in which artificial cement is injected under fairly high pressure (eg, vertebroplasty, vertebral augmentation) it is imperative to maintain high venous pressure to avoid embolic events. In particular, the patients tend to have cardiopulmonary fragility to the extent that the hemodynamic changes engendered by these techniques require significant work by the anesthesiologist to maintain hemodynamic homeostasis.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01905

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

Specialty Anesthesia	How often? Sometimes
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 20000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesia	Frequency 20000	Percentage	100
Specialty	Frequency	Percentage	
Specialty	Frequency	Percentage	

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesia	Frequency 10000	Percentage	10000.00%
Specialty	Frequency	Percentage	
Specialty	Frequency	Percentage	

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

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor:

01935 **Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic**

01936 **Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic**

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

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

We are requesting the standard anesthesia PE package as approved by the PERC/RUC in April 2006

CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiology of 11 minutes and agreed that this was a direct practice expense however 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

3 minutes - anesthesia scheduling

5 minutes - case assignment, scheduling coordination and completion of forms

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1				CPT Code 01935		CPT Code 01936	
2	April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Anesthesia for percutaneous image guided procedures on the spine		Anesthesia for percutaneous image guided procedures on the spine	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			0.0	8.0	0.0	8.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	8.0	0.0	8.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	Anesthesia scheduling	L037D	RN/LPN/MTA	NA	3	NA	3
18	Case assignment, scheduling coordination and completion of forms	L037D	RN/LPN/MTA	NA	5	NA	5
19	**End:When patient enters office/facility for surgery/procedure**						
20	SERVICE PERIOD						
21	**Start: When patient enters office/facility for surgery/procedure**						
22	**Pre-service services**						
23	Review charts						
24	Greet patient and provide gowning						
25	Obtain vital signs						
26	Provide pre-service education/obtain consent						
27	Prepare room, equipment, supplies						
28	Setup scope (non facility setting only)						
29	Prepare and position patient/ monitor patient/ set up IV						
30	Sedate/apply anesthesia						
31	**Intra-service**						
32	Assist physician in performing procedure						
33	**Post-Service**						
34	Monitor pt. following service/check tubes, monitors, drains						
35	Clean room/equipment by physician staff						
36	Clean Scope						
37	Clean Surgical Instrument Package						
38	Complete diagnostic forms, lab & X-ray requisitions						
39	Review/read X-ray, lab, and pathology reports						
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
41	Discharge day management 99238 --12 minutes 99239 --15 minutes						
42	Other Clinical Activity (please specify)						
43	**End: Patient leaves office**						
44	POST-SERVICE PERIOD						
45	**Start: Patient leaves office/facility**						
46	Conduct phone calls/call in prescriptions						
47	*Office visits:*						
48	*List Number and Level of Office Visits*						
49	99211 16 minutes		16				
50	99212 27 minutes		27				
51	99213 36 minutes		36				
52	99214 53 minutes		53				
53	99215 63 minutes		63				
54	Other						
55							
56	*Total Office Visit Time*			0	0	0	0
57	Other Activity (please specify)						
58	**End: with last office visit before end of global period**						
59	[illegible]	CMS Code	[illegible]				
60	No Supplies	SX007					
61	[illegible]	CMS Code	[illegible]				
62	No Equipment	EZ007					
63							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Soft Tissue Brachytherapy Implant Placement

In February 2007, the CPT Editorial Panel created a new Category I code to provide more specificity in describing the surgical placement of brachytherapy needles or catheters. The new code describes the placement of brachytherapy needles and/or catheters into muscle and/or soft tissue.

The RUC reviewed the specialty society's survey of 47 radiation oncologists for code 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* and agreed that those surveyed had overestimated the pre-service evaluation and positioning time associated in comparison to similar services. The RUC determined that code 20555 is similar in physician work, time and intensity to 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance* (work RVU = 6.00), which is the same value as the lowest work RVU response from the specialty's survey. The RUC also agreed that the physician time pre-service evaluation time should be similar to that of code 19298.

The RUC recommends the physician work relative value of 6.00 for code 20555. (with a pre-service evaluation time of 30 minutes, positioning of 5 minutes,15 minutes for scrub, dress, and wait, intra-service time of 70 minutes, and an immediate post service time of 30 minutes.)

Practice Expense

The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service.

CPT Code (•New)	Tracking Number	CPT Code Descriptor	Global Period	Work RVU Recommendation
●20555	Q1	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)	000	6.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Code Descriptor	Global Period	Work RVU Recommendation
		(For placement of devices into the breast for interstitial radioelement application use 19296-19298) (For placement of needles, catheters, or devices into muscle or soft tissue of the head and neck, for interstitial radioelement application, use 41019) (For placement of needles or catheters for interstitial radioelement application into prostate, use 55875) For placement of needles or catheters into the pelvic organs or genitalia (except prostate) for interstitial radioelement application, use 55920) (For interstitial radioelement application, see 77776-77784) (For imaging guidance, see 76942, 77002, 77012, 77021)		

CF digit codes, two-digit modifiers, and descriptions only are copyright American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20555 Tracking Number Q1 Specialty Society Recommended RVU: **8.00**
Global Period: 000 RUC Recommended RVU: **6.00**

CPT Descriptor: Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year old man presents with a painful mass in the anterior thigh. MRI confirms a 12 cm infiltrative mass in the anterior compartment of the thigh. Incisional biopsy shows a high grade liposarcoma. Following wide surgical resection of the mass, catheters are implanted throughout and surrounding the tumor bed for subsequent afterloading brachytherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 41%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review initial exams, radiation and chemotherapy records including related toxicities and current labs. Obtain consent and educate patient and family about procedure. Review preoperative imaging and plan catheter placement. Discuss implant volume, placement and spacing with the brachytherapy team. Select, assemble, and ᶜ necessary order requisite brachytherapy catheters and supplies. Dress, scrub and wait. The anatomic extent of the ɹmor is outlined on the patient's skin and the margins for brachytherapy implantation discussed with the orthopedic surgical oncologist. The patient is positioned and prepped The gross tumor is resected by the surgeon and the wound left open for the brachytherapy catheter placement.

Description of Intra-Service Work: Clips are placed to mark the 3-dimensional relationships of the tumor margins. An implant is designed accounting for directionality and wound closure and appropriate implant catheters are selected.

Entrance and exit sites are outlined on the skin surface with a sterile marking pen. Needles are introduced through a transcutaneous needle stick. The leader portion of the catheter is inserted into the needle and exited within the wound. The needle and catheter are pulled into the wound and the needle is removed. The catheter has a button on the end to fix it to the skin and prevent it from pulling through the skin at the entrance site. A series of Jackson-Pratt (JP) drainages are inserted perpendicular to the direction of the implant catheters to create a scaffolding. The leader portion of the catheters is threaded through the drain wholes in the JP drainages in series. Another skin stick is then performed to create an exit site, the catheter is inserted and the needle is removed. The catheter is fixed into position by an additional color-coded fixing buttons.

The catheters are inserted one at a time until a total of 30 implant catheters have been placed. As each catheter is placed the relationship of one catheter to the next and the relationship of the implant to the target volume is assessed. During the course of the implant procedure the wound margins are approximated to ensure that wound closure will not become problematic. The entrance and exit fixing buttons are brought down snug but not tight to the skin. The wound is closed by the surgeon. Excess leader and catheter ends are cut and discarded. The stiffening leader within the catheters is removed with wire strippers. The radiation oncologist designs and places a dressing so that the catheters are not ɹmaged.

Description of Post-Service Work: The radiation oncologist then diagrams the implant in the patient's medical record; dictates the procedure report and write orders. The patient is examined, paying close attention to catheter wounds. The physician then communicates with physics/dosimetry staff regarding subsequent radioelement application and answers all patient and family questions. Coordinates post operative imaging.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Najeeb Mohideen, M.D., Michael Kuettel, M.D., MBA, PhD, David Beyer, M.D.				
Specialty(s):	Radiation Oncology				
CPT Code:	20555				
Sample Size: 591	**Resp N:** 47	**Response:** 7.9 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	1.00	**3.00**	5.00	30.00
Survey RVW:	6.00	8.00	**13.18**	15.00	49.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**17.5**		
Intra-Service Time:	30.00	60.00	**70.00**	90.00	180.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

lowever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 20555		
		Specialty Recommended
Physician Work RVU:		8.00
Pre-Service Evaluation Time:		30.0
Pre-Service Positioning Time:		5.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		70.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

› the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55875	090	13.31	RUC Time

CPT Descriptor Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
43269	000	15,294	8.20	RUC Time

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

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

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 42.5 %

TIME ESTIMATES (Median)

	CPT Code: 20555	Key Reference CPT Code: 55875	Source of Time RUC Time
Median Pre-Service Time	50.00	50.00	
Median Intra-Service Time	70.00	90.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**150.00**	**249.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.20	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.26	3.80
Urgency of medical decision making	4.00	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.61	4.50
Physical effort required	4.33	3.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.43	415.00
Outcome depends on the skill and judgment of physician	4.70	4.45

Estimated risk of malpractice suit with poor outcome	4.28	4.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.91	3.50
Intra-Service intensity/complexity	4.37	4.15
Post-Service intensity/complexity	3.98	3.50

Additional Rationale

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

Almost fifty physician work surveys were completed by our membership for this new CPT code. The data from those surveys were collected, reviewed and analyzed by a consensus panel, consisting of members of ASTRO's Health Policy ıd Code Development and Valuation Committee, as well as brachytherapy experts in the field of radiation oncology. .he group reviewed the surveyed data and feels that the data supports a recommendation to accept the 25th percentile RVU value of 8.00.

The panel reviewed the data for this new CPT code, along with the reference service code and the two other new CPT codes for similar procedures, being presented at this RUC meeting. The panel has reviewed the family of these codes and feels that following is an appropriate rank order:

Surveyed Code:	41019	IWPUT 0.09723
Reference Service Code:	55876	IWPUT 0.09482
Surveyed Code:	55920	IWPUT 0.09167
Surveyed Code: ***(this survey)***	**20555**	**IWPUT 0.083**

The panel feels the procedure described by this new CPT code is less intense then the work described in the reference service code and the other two new procedure codes.

The panel also recommends that the median surveyed are appropriate for this procedure (*one exception) and therefore should be entered into the RUC database: 30 minutes day preceding, 15 minutes of pre-service evaluation time, 15 minutes for pre-service positioning, 70 minutes of intra-service time, and 30 minutes of immediate post-service time. The society recommends 15 minutes for pre-service scrub, dress and wait be entered into the RUC database, instead of the median of 17.5.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
CPT code 20999; Unlisted procedure, musculoskeletal system, general.

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

Specialty Radiation Oncology How often? Sometimes

Specialty Orthopedic Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This type of procedure will most likely be done infrequently, and will almost always be done by a radiation oncologist. There may be occasional instances when it will be performed by a surgeon and therefore we have indicated that below.

Specialty Radiation Oncology Frequency 360 Percentage 90.00 %

Specialty Orthopedic Surgery Frequency 40 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that approximately 2/3 of the total number of times this service us provided annually (400 as indicated above) will be performed on patients in the Medicare program. Again, the procedure will most likely be performed by a radiation oncologist, however, an orthapedic surgeron may perform this procedure.

Specialty Radiation Oncology Frequency 270 Percentage 90.00 %

Specialty Orthopedic Surgery Frequency 30 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

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

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 19298

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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

CPT Long Descriptor: Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)

Sample Size: N/A **Response Rate: (%):** N/A **Global Period:** 000

EXPERT PANEL USED TO DEVELOP RECOMMENDATION

Geographic Practice Setting %: **All geographic practice settings represented.**

Type of Practice %: **All practice types represented.**

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

The American Society of Therapeutic Radiology and Oncology (ASTRO) prepared these practice expense reccommendations using a consensus panel of physicians comprised of members from ASTRO's Health Policy Committee, Code Development and Valuation Committee (CDVC), as well as those physicians that perform brachytherapy implant placement procedures. The consensus panel included physician representatives from states in various regions of the United States and all demographic areas.
The consensus panel members held several conference calls to evaluate the non-physician clinical labor times, medical supplies, and equipment, based upon the panel members' experience with the procedure under consideration. Preliminary recommendations for direct inputs were drafted and distributed for discussion by the panel during these conference calls, which led to the final formulated practice expense recommendations for CPT® code 20555; *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)*. Although ASTRO was also scheduled to make non-facility practice expense recommendations for this procedure, we felt that it was appropriate to only make recommendations for the facility setting at this time.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Schedule procedure, confirm all applicable supplies and devices are available.

Retrieve and compile all relevant clinical information, including all preoperative imaging studies, and patient's medical record for review by the physician. Verify orders, and confirm procedure protocol with physician.

Contact patient on the day before the procedure to provide educational information regarding the procedure and provide them with any additional information they may request. Obtain informed consent and confirm adherence to pre procedure protocol.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Initiate phone calls for physician and call in prescriptions as applicable.

	A	B	C	D	E
2				20555	
3	**Meeting Date: April 2007** **AMA Specialty Society RVS Update Committee Recommendation**			*Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure).*	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**33.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**30.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**3.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms	**L037D**	**RN/LPN/MTA**		**5**
13	Coordinate pre-surgery services	**L037D**	**RN/LPN/MTA**		**10**
14	Schedule space and equipment in facility	**L037D**	**RN/LPN/MTA**		**5**
15	Provide pre-service education/obtain consent	**L037D**	**RN/LPN/MTA**		**7**
16	Follow-up phone calls & prescriptions	**L037D**	**RN/LPN/MTA**		**3**
17	Other Clinical Activity (please specify)				
18	**End:When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning	**L037D**	**RN/LPN/MTA**		
24	Obtain vital signs	**L037D**	**RN/LPN/MTA**		
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies	**L037D**	**RN/LPN/MTA**		
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV	**L037D**	**RN/LPN/MTA**		
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure	**L037D**	**RN/LPN/MTA**		
32	**Post-Service**				
33	Monitor pt. following service/check tubes, monitors, drains	**L037D**	**RN/LPN/MTA**		
34	Clean room/equipment by physician staff	**L037D**	**RN/LPN/MTA**		
35	Clean Scope	**L037D**	**RN/LPN/MTA**		
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	**RN/LPN/MTA**		
40	Discharge day management 99238 –12 minutes 99239 –15 minutes				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				
43	**POST-SERVICE PERIOD**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions	**L037D**	**RN/LPN/MTA**		**3**
46	*Office visits:*				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		**16**		
49	99212 27 minutes		**27**		
50	99213 36 minutes		**36**		
51	99214 53 minutes		**53**		
52	99215 63 minutes		**63**		
53	Other				
54					
55	*Total Office Visit Time*			**0**	**0**
56	Other Activity (please specify)				
57	**End: with last office visit before end of global period**				
58	**MEDICAL SUPPLIES**	**CMS Code**	**Staff Type**		
59	pack, drapes, cystoscopy	**SA045**	**pack**		
60	pack, minimum multi-specialty visit	**SA048**	**pack**		
61	syringe 20ml	**SC053**	**item**		
62	needle, spine, Sprotte	**SC042**	**item**		
63	cover-condom, transducer or ultrasound probe	**SB005**	**item**		
64	kit, gold markers, fiducial, 3 per kit	**N/A**	**kit**		
65	lidocaine 1%-2% inj (Xylocaine)	**SH047**	**ml**		
66					
67	**EQUIPMENT**	**CMS Code**	**Staff Type**		
68	table, power	**EF031**			
69					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Application of Cranial Tongs

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they felt should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 20660 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 20660 to the RUC. Code 20660 had never been surveyed nor discussed at the RUC previously. The RUC understood that it was tasked with considering whether 20660 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 20660.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post service periods which disqualifies 20660 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

Based on the above criteria, the RUC concurs with the CPT Editorial Panel that 20660 be removed from the Modifier -51 Exempt List.

The RUC considered whether there is compelling evidence for re-valuation of 20660. The specialty society explained that when 20660 is performed as part of a surgical procedure to stabilize the neck, that it is bundled with that surgical code. The RUC understood that it was considering the service described by 20660 only when it is done as a stand-alone code. The RUC noted that it is often performed with an E/M service. The RUC agreed that removal from the -51 exempt modifier list was an adequate reason for re-valuation.

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The RUC reviewed the specialties' survey results in order to value the service. Code 20660 was originally valued by Harvard and recommended to CMS as a 090 day global service in 1992 with a work RVU of 3.81. In 1993, CMS dropped the value to 2.57 and changed the service to a 000 day global, and placed 20660 on the -51 Modifier Exempt list.

The RUC agreed that survey respondents mis-classified some intra-service time for 20660. Specifically, physician work of positioning the patient was classified by survey respondents as pre-service. The RUC and specialties agreed that due to the critical nature of injury in these patients (unstable cervical fracture), the physician's intra- work begins when he personally stabilizes the neck while transferring the patient to the traction bed. All participants agreed to reallocate 15 minutes of pre-service positioning time to the intra-service period, and eliminate 10 minutes of pre-service evaluation time. All changes of physician time are shown in the table below and were used in the following crosswalks.

Physician Time	Pre-Eval	Pre-Positioning	Pre-Scrub, Dress, Wait	Intra-Service	Immediate Post	Total Physician Time
Original Rec	20	0	15	47	19	101
RUC Rec	**20**	**0**	**10**	**30**	**30**	**90**

The RUC compared the service to MPC listed code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU = 3.69, 000 global). CPT Code 20660 and 19103 have the same amount of intra-service time, 30 minutes although CPT code 20660 requires a higher intensity to complete. Based on the specialties' survey results, an enhanced understanding of the service resulting in a reallocation of physician time, and comparisons of similar services across specialties, the RUC believed the specialty societies survey median of 4.00 work RVUs was appropriate. **The RUC recommends a relative work value of 4.00 RVUs for code 20660.**

Practice Expense

After further discussion with the specialty societies, it became clear that 20660 is not performed in the non-facility setting. **The RUC recommends no practice expense inputs in the facility and non-facility settings.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲20660	DD1	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	000	4.00

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20660 Tracking Number DD1 Specialty Society Recommended RVU: **2.51**
Global Period: 000 RUC Recommended RVU: **4.00**

CPT Descriptor: Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18 year old male in automobile crash presents to the emergency department with neck pain and upper extremity weakness. Radiographs demonstrate a cervical spine fracture, focal kyphosis and subluxation of adjacent cervical vertebrae. Cranial tongs are applied for emergent cervical spine protection and stabilization while planning additional work-up and imaging studies.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 61%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews spinal imaging studies, the past medical history and appropriate lab studies. Informed consent with the patient and family are obtained. The patient is examined neurologically just prior to placement of cranial tongs. Subsequently, the work of pre-op shave, prep, scrub and equipment setup including bed attachments of pulley system and the rope, weights, hooks, and tongs is performed. The height and angle of the pulley system are established to obtain the ideal vector of traction for the particular fracture type.

Description of Intra-Service Work: The skin above the ear on both sides of the head is injected with a local anesthetic. The cranial tongs are positioned and betadine ointment is placed on the pin tips. The pins are then serially d gradually advanced through the skin bilaterally until they are firmly situated in the outer table of the cranium. Often, additional local anesthetic is added as the pins penetrate deeper. The pressure indicator is examined to insure that the pins are not advanced too far. Slight manual traction is applied in ensure secure positioning in the skull's outer table.

Description of Post-Service Work: The tongs are connected by a cord over a pulley to a set of weights that provide traction. Post-operative x-rays are reviewed to insure that the dislocation is reduced and/or there is not any over distraction of the unstable level. The patient is stabilized and closely observed with neurological reexamination for any post-traction neurological deterioration. An operative report is dictated. The surgeon communicates with the family and referring physician (including written and telephone reports and orders). Several days later, after surgical internal stabilization of the spine, the tongs are removed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Frederick Boop, MD; John Wilson, MD, Robert Blasier, MD, Claire Tibiletti, MD		
Specialty(s):	AANS, CNS, AAOS, NASS		
CPT Code:	20660		
Sample Size:	500	**Resp N:** 190	**Response:** 38.0 %
ample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	12.00	409.00
Survey RVW:	1.00	3.00	**4.00**	5.00	20.00

Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		2.00	10.00	**15.00**	30.00	120.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

lowever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 20660		
		Specialty Recommended
Physician Work RVU:		2.51
Pre-Service Evaluation Time:		20.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		30.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

; the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61107	000	4.99	RUC Time

CPT Descriptor Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99284	XXX	5,622,913	2.56	RUC Time

CPT Descriptor 1 Emergency department visit for the evaluation and management of a patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the ıture of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, ıd require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 85 **% of respondents:** 44.7 %

TIME ESTIMATES (Median)	CPT Code: 20660	Key Reference CPT Code: 61107	Source of Time RUC Time
Median Pre-Service Time	30.00	0.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	30.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**90.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.79	3.51
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.89	3.71
Urgency of medical decision making	4.24	4.44
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.96	3.43
Physical effort required	2.80	2.94
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.93	4.01

Outcome depends on the skill and judgment of physician	4.06	4.08
Estimated risk of malpractice suit with poor outcome	4.54	4.22

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.84	3.81
Intra-Service intensity/complexity	3.08	3.41
Post-Service intensity/complexity	3.45	3.45

Additional Rationale

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

In the Harvard submission to CMS in March 1992 (preliminary phase 3D data), code 20660 was studied as a 090-day obal code. Intraservice work on the Harvard scale was 230 and pre/post work on the Harvard scale was 230 equal to a .otal Harvard work value of 460. The 1992 MFS valued this code at less than total work (1992 RVW=3.81, instead of 4.64) with a 090-day global period. In 1993, the MFS RVW for this code was reduced to 2.57, the global period was changed to 000, and one hospital visit and 3 office visits from the Harvard study were removed from the database. The value of 2.57 is approximately equal to the Harvard intra work of 230, scaled to the MFS, which indicates a 50% reduction was applied to the new value in 1993 when the global period was changed. CMS multiple procedure rule = "0" (ie, does not apply) confirms the 50% reduction is already in place for this code. Additionally, note that the full descriptor for this code reads: Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure). The pre and post time for this code are clinically separate from evaluation and management services and are related specifically to the work of this procedure alone and not redundant for any additional procedures that may be performed. Therefore CMS accepted this code as -51 modifier exempt.

We believe that the value for this code at 2.51 may be understated, given the intensity and complexity of the patients that require this procedure, typically performed for a cervical fracture/dislocation. However, we understand that the undervaluation as demonstrated by the survey is a five year review issue and therefore we are recommending that the current value and -51 modifier exempt status remain unchanged. We believe our survey data not only validate this recommendation, but support identification of this code as misvalued such that it should be reconsidered at the next five year review.

Our panel reviewing the survey was surprised by the survey result that showed 61% of the time conscious sedation was used and they wondered if the surveyees thought that local anesthetic qualified as conscious sedation. Our panel does not believe that conscious sedation is typically used with this code.

ERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) A separately identifiable evaluation and management service may be performed to identify the type of injury that would require placement of axial cervical traction using cranial tongs.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. An evaluation and management code (typically 99253-99255) would be reported with either the -25 or -57 modifier on the same day of service.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20660

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

Specialty Neurosurgery How often? Sometimes

Specialty Orthopaedic Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. The Medicare frequency for this code is 3,261. Many of the patients who undergo this procedure are automobile accident victims and are younger than the Medicare age population. We would estimate that the Medicare population is about one third of the total national number.

Specialty Orthopaedics Frequency 3000 Percentage 30.00 %

Specialty Neurosurgery Frequency 6000 Percentage 60.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,261 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. This is the 2005 frequency from the RUC database

Specialty Orthopaedics Frequency 1000 Percentage 30.66 %

Specialty Neurosurgery Frequency 2000 Percentage 61.33 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

External Fixation

At the February 2007 CPT Editorial Panel meeting, the Panel accepted the request to establish two codes: 20695 *Stereotactic computer-assisted adjustment of multi-planar dynamic external fixation system (eg, spatial frame), including imaging; initial alignment, assessment and computation of adjustment schedule(s)*and 20696 *Stereotactic computer-assisted adjustment of multi-planar dynamic external fixation system (eg, spatial frame), including imaging; exchange of each strut* to report stereotactic, computer-assisted adjustment of multiplanar dynamic external fixation systems. In consideration of this request at the April 2007 RUC meeting, it was recommended, at the request of the specialties, that the codes be rescinded. This action would allow the specialties the opportunity to revise the descriptors to more accurately describe the service specifically to clarify that the computerized schedule is distinct from the application of the fixation device. The CPT Executive Committee reviewed this request made by the specialty society and the RUC and agreed that these codes should be rescinded. **The CPT Executive Committee rescinds CPT codes 20695 and 20696.**

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* be removed from the Modifier -51 Exempt List. The Workgroup asked specialty societies to review the list and bring back any code they believed should be retained on the list. At the February 2007 CPT meeting, the specialty societies asked to retain 20690 and 20692 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 20690 and 20962 to the RUC. The RUC understands that it is tasked with considering whether 20690 and 20692 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 20690 and 20692.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of these services and the history of their value. The specialty societies and the RUC understood that both of these services have significant time in the pre-service and post service periods which would disqualify 20690 and 20692 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

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FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

As both of these procedures have significant pre-service and post-service times associated with them, the RUC agreed with the specialty society that these codes should be valued as stand alone procedures and should be removed from the Modifier -51 Exempt List. **The RUC concurs with the CPT Editorial Panel that 20690 and 20692 be removed from the Modifier -51 Exempt List.**

As the RUC works under the presumption that all services on the physician fee-schedule are correctly valued, the specialty society provided compelling evidence to support its recommendation of 8.65 RVUs for 20690 and 16.00 RVUs for 20692, which is an increase over the existing value of 20690 and 20692, 3.67 and 6.40 RVUs respectively. The specialty society explained that the codes had never been reviewed by the RUC as 090 day global procedure.

In the Harvard submission to CMS in March 1992 , code 20690 was studied as a 090-day global. However CMS shose not to use the Harvard data and the 1992 MFS published RVW was 3.71 with a ZZZ global period. From 1992 to 1999 (interim), the global period was ZZZ. From 1999 to present, the global period is 090. No explanation was provided in any Federal Register text about this change. A similar history exists for CPT code 20692. In the Harvard submission to CMS in March 1992, code 20692 was studied as a 090-day global code The 1992 MFS published RVW was 6.76 with a ZZZ-day global period. Additional sources confirm a ZZZ global period through 1998. From 1999 to present, the global period is 090. No explanation was provided in any Federal Register text about this change.

Given this history, it is clear that the current values and time information are not related to a code with a 90-day global period. Additionally, it is clear that these codes have never been properly reviewed by the RUC. The RUC reviewed this compelling evidence and agreed with the specialty that there is evidence that incorrect assumptions were made in the previous valuation of the service.

The RUC reviewed the specialty societies' survey results for 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and thoroughly discussed the physician time and work associated with this service in comparison to its reference code 24566 *Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation* (Work RVU=8.86). The specialty society modified the pre-service time associated with the surveyed code to better reflect the pre-service time evaluation associated with this procedure. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is the same as the surveyed code, 60 minutes. Additionally, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires more overall intensity to perform than the surveyed code. Therefore, the RUC agreed that because of the same amount of intra-service time and the greater overall intensity associated with the reference code in comparison to the surveyed code, the RUC recommends the

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25th percentile of the survey data, 8.65 RVUs for 20690. The RUC believes that this value appropriately places the surveyed code in comparison to the reference code. **The RUC recommends 8.65 work RVUs for 20690.**

The RUC reviewed the specialty societies' survey results for 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* and thoroughly discussed the physician time and work associated with this service in comparison to its reference code 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* (Work RVU=23.04). The specialty societies modified the post-operative visits associated with the surveyed code to better reflect the post-operative care associated with this procedure. After considerable review, the specialty societies offered another reference code as they believed the reference code selected by the survey respondents was not appropriate. The specialty societies proposed CPT code 20664 *Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia* (Work RVU=9.86). The specialty society stated that 20692 had significantly more total time associated with it in comparison to the proposed reference code, 474 minutes and 405 minutes, respectively. Further, the specialty societies agreed that 20692 was a significantly more complex procedure to perform than 20664. Therefore, the RUC agreed that because the surveyed code has significantly more total service time associated with it and the greater overall intensity associated with the surveyed code in comparison to the proposed reference code, the RUC recommends the 25th percentile of the survey data, 16.00 RVUs for 20692. The RUC believes that this value appropriately places the surveyed code in comparison to the reference code. **The RUC recommends 16.00 work RVUs for 20692.**

47

Practice Expense:
The RUC reviewed the specialty societies recommended practice expense inputs for 20690 and 20692. The RUC noted that the specialty societies recommended the standard 090 day global practice expense input packages for these procedures. However, the specialty recommended and the RUC agreed that the pre-service time for 20690 performed in the facility be removed as this procedure is typically emergent. The revised practice expense recommendation are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
20690	R1	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system	090	8.65
20692	R2	Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	090	16.00

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
D ●20695	R3	~~Stereotactic computer-assisted adjustment of multi-planar dynamic external fixation system (eg, spatial frame), including imaging; initial alignment, assessment and computation of adjustment schedule(s)~~	090	CPT Code Rescinded by the CPT Executive Committee
D ●20696	R4	~~exchange of each strut~~	090	CPT Code Rescinded by the CPT Executive Committee

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20690 Tracking Number R1 Specialty Society Recommended RVU: **8.65**
Global Period: 090 RUC Recommended RVU: **8.65**

CPT Descriptor: Application of a uniplane (pins or wires in one plane), unilateral, external fixation system

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old male sustains a comminuted fracture of his proximal right tibia and fibula in a motorcycle crash requiring external fixation. Application of a uniplanar, half-pin external fixator is planned spanning the knee and fracture, extending from the femur to the tibia.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark pin sites
- The leg is prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
The procedure contemplates that the fracture has already been reduced by other means. A spanning fixator will be placed from the femoral shaft down to the tibial shaft across the fracture site. A minimum of two pins sites are selected on the femur and at least two on the tibia. The pins are placed so as to minimize danger to neurovascular structures and impalement of musculotendinous units. After the pin sites are selected, the following procedures are performed for each pin site:A 1.5 cm incision is made in the skin over each intended insertion site on at a time. A tonsilar hemostat is used to spread the soft tissues down to the level of the bone. A trochar is passed down to the level of the bone to protect soft tissues. A drill is passed through the trochar down to the bone and used to drill through both cortices of the bone. The drill is with drawn and a threaded fixator pin is drilled into the bone across both cortices. Stability of the pin is tested by manual stressing it. After the pins are inserted, they are connected to a bar construct which spans from the femur to tibia using rod-pin connectors. The set screws are provisionally tightened. Reduction of the fracture and alignment are checked by radiographs. The set screws are fully tightened. Skin tracts are released where there is tension on the skin

escription of Post-Service Work: Post-service work: in facility
- Sterile dressings are applied.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Order and review periodic films
- Assess circulation, sensation and motor function of the extremity
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; William Beach, MD				
Specialty(s):	AAOS, OTA, AOFAS				
CPT Code:	20690				
Sample Size: 200	**Resp N:** 35	**Response:** 17.5 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	3.00	**10.00**	18.00	30.00
Survey RVW:	6.00	8.65	**11.00**	14.00	21.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	20.00	43.00	**60.00**	75.00	150.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**			
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**			
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

.owever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 20690		
		Specialty Recommended
Physician Work RVU:		8.65
Pre-Service Evaluation Time:		30.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24566	090	8.86	RUC Time

CPT Descriptor Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

_PT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
25606	090	8.10	RUC Time

CPT Descriptor Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)

	CPT Code: 20690	Key Reference CPT Code: 24566	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	62.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**300.00**	**257.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.33
Urgency of medical decision making	4.43	4.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.57	3.50
Physical effort required	3.71	3.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.67
Outcome depends on the skill and judgment of physician	4.00	3.67
Estimated risk of malpractice suit with poor outcome	4.00	4.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
'me Segments (Mean)		
,re-Service intensity/complexity	3.21	2.67
Intra-Service intensity/complexity	2.71	3.00
Post-Service intensity/complexity	3.14	2.83

Additional Rationale

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

CPT codes 20690 and 20692 have been discussed at (at least) the last two CPT Panel meetings. Two issues have brought these codes to the RUC for review: 1) the codes have been taken off of the -51 modifier exempt list; and 2) the codes have never been reviewed as 90-day globals and were part of a review of ORIF codes. Below is a history of database information for each code:

'story 20690:

In the Harvard submission to CMS in March 1992 (preliminary phase 3D data), code 20690 was studied as a 090-day global code with a vignette of "Application of external fixation system (eg, Hoffman)". The recorded times were 32/80/20 (pre/intra/post), 2 hospital, and 4 office visits. Total Harvard time was 206 minutes and total Harvard work was 481 (or 4.90 scaled to the MFS).

The 1992 MFS published RVW was 3.71 with a ZZZ global period. [From Harvard, this code had a final "pack" or global designation of "sss" which denotes a secondary code (usually billed in addition to another service).]

In 1999, the Harvard times (noted above) were discarded and a predicted total time of 99 minutes was implemented for practice expense purposes.

From 1992 to 1999(interim), the global period was ZZZ. In 1998, the RVW was 3.52.

Additional sources confirm a ZZZ global period through 1998. In 1997, the CPEP(3) data list zero for post-op visits. Also, in 1997, Dan Dunn's file submission to CMS regarding increases in the payment for global services due to the increase in EM services after the first 5YR, listed this code as having a ZZZ global period.

From 1999(final) to present, the global period is 090. In 2007, the RVW is 3.67. No explanation was provided in any Fed Reg text about this change.

'Iistory 20692:

ın the Harvard submission to CMS in March 1992 (preliminary phase 3D data), code 20692 was studied as a 090-day global code with a vignette of "Applic. of a multiplane, unilat., ext fixation syst". The only recorded time was 114 minutes for intra time and Harvard intra work was presented as 392.

The 1992 MFS published RVW was 6.76 with a ZZZ-day global period. [From Harvard, this code had a final "pack" or global designation of "sss" which denotes a secondary code (usually billed in addition to another service).]

In 1999, the Harvard times (noted above) were discarded and a predicted total time of 159 minutes was calculated for practice expense purposes.

From 1992 to 1999(interim), the global period was ZZZ. In 1998, the RVW was 6.41.

Additional sources confirm a ZZZ global period through 1998. In 1997, the CPEP(3) data list zero for post-op visits. Also, in 1997, Dan Dunn's file submission to CMS regarding increases in the payment for global services due to the increase in EM services after the first 5YR, listed this code as having a ZZZ global period.

From 1999(final) to present, the global period is 090. In 2007, the RVW is 6.40. No explanation was provided in any Fed Reg text about this change.

Given this history, it is clear that the current values and time information are not related to a code with a 90-day global period. Additionally, it is clear that these codes have never been properly reviewed and have values that are based on prediction.

RATIONALE FOR RECOMMENDATION:

In response to the CPT changes and a request by the RUC and CMS, A survey was sent to orthopaedic surgeons representing general orthopaedics, trauma, and foot and ankle surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services. The panel agreed that both 20960 and 20962 can be performed as a stand alone code for fixation of a fracture or deformity and therefore should correctly have a global period of 90-days. Further, the panel agreed that the current values for the codes are not based on 90 days of care.

20690: The panel compared 20690 to two equally cited key reference codes 24566 (Percutaneous skeletal fixation o. humeral epicondylar fracture, medial or lateral, with manipulation) and 25606 (Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation). The typical patient requiring 20690 will likely be a trauma victim and will required admission to the hospital, with greater postoperative work compared to the reference codes. The survey median RVW of 11.00 (IWPUT=0.056) is recommended. This value correctly sets 20690 greater than the reference codes, taking into consideration the significant postoperative work for these patients.

20692: The panel compared 20692 to key reference code 27447 (total knee). The intra-service times and hospital visits are similar for both codes, however, 20692 would require significantly more office visits. The survey median RVW of 21.00 (IWPUT=0.069) is recommended. This value correctly sets 20692 less than 27447 because the panel felt that the greater intensity of 27447 outweighed the additional office visits for 20692.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20690

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

Specialty ortho How often? Commonly

Specialty podiatry How often? Sometimes

Specialty How often?

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

Specialty Frequency Percentage %

›ecialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
4,100 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. database

Specialty ortho Frequency 3485 Percentage 85.00 %

Specialty podiatry Frequency 410 Percentage 10.00 %

Specialty others Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

˜no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20692 Tracking Number R2 Specialty Society Recommended RVU: **16.00**
Global Period: 090 RUC Recommended RVU: **16.00**

CPT Descriptor: Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male, with an acquired limb length discrepancy and tibial non-union (the result of a prior trauma) is scheduled for reconstructive surgery using a multiplanar, tensioned wire external fixation system designed for deformity correction and controlled mechanical distraction osteogenesis.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark pin sites
- • The leg is prepped and draped.
- A detailed plan for gradual mechanical correction of the deformity, docking and compression at the non-union site and mainaitainace until complete healing. This is completely detailed for the patient.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
The procedure contemplates placing pin clusters above and below the deformed nonunion and connecting the clusters to screw driven actuators which will gradually correct the deformity, compress it for healing and the immobilized it until complete consolidation. A spanning fixator will be placed from the proximal tibia down to the distal tibia across the deformity site. A minimum of two pins sites are selected on proximal tibia and at least two on the distal tibia. The pins are placed so as to minimize danger to neurovascular structures and impalement of musculotendinous units. After the pin sites are selected, the following procedures are performed for each pin site: Pins may be either fine wires which completely pass through the leg and tibia or stouter half-pins which are placed unilaterally. Fine wires are drilled through skin across the bone and out the other side. Half pins are inserted as follows: A 1.5 cm incision is made in the skin over each intended insertion site on at a time. A tonsilar hemostat is used to spread the soft tissues down to the level of the bone. A trochar is passed down to the level of the bone to protect soft tissues. A drill is passed through the troch down to the bone and used to drill through both cortices of the bone. The drill is withdrawn and a threaded fixator pin drilled into the bone across both cortices. Stability of the pin is tested by manual stressing it. After each cluster of pins is inserted, they are connected to a multi-pin connector or ring. Fine wires may need to be tensioned to maintain stiffness of the device. The clusters are then connected by screw-activated struts which will be used to gradually correct and

compress the deformity. The set screws are provisionally tightened. Placement of the device and alignment are checked by radiographs. The set screws are fully tightened. Skin tracts are released where there is tension on the skin

Description of Post-Service Work:
ost-service work: in facility
sterile dressings are applied.

- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions

Order and review periodic films
Assess circulation, sensation and motor function of the extremity

- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; William Beach, MD				
Specialty(s):	AAOS, OTA, AOFAS				
CPT Code:	20692				
Sample Size: 200	**Resp N:** 35	**Response:** 17.5 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**3.00**	7.00	40.00
Survey RVW:	14.00	16.00	**21.00**	25.00	30.00
e-Service Evaluation Time:			**70.0**		
re-Service Positioning Time:			**18.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	75.00	108.00	**120.00**	150.00	300.00

Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	80.0	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**
Office time/visit(s):	164.0	99211x **0.0** 12x **2.0** 13x **4.0** 14x **1.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 20692		
		Specialty Recommended
Physician Work RVU:		16.00
Pre-Service Evaluation Time:		70.0
Pre-Service Positioning Time:		18.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 3.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	133.0	99211x 0.0 12x 4.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27447	090	23.04	RUC Time

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)	CPT Code: 20692	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	103.00	75.00	
Median Intra-Service Time	120.00	124.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	133.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**474.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.50	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	3.30
Urgency of medical decision making	3.07	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.79	3.50
Physical effort required	4.36	3.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.36	3.40
Outcome depends on the skill and judgment of physician	4.79	3.70

Estimated risk of malpractice suit with poor outcome	3.79	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.71	3.30
Intra-Service intensity/complexity	4.64	3.60
Post-Service intensity/complexity	4.43	2.70

Additional Rationale

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

CPT codes 20690 and 20692 have been discussed at (at least) the last two CPT Panel meetings. Two issues have brought these codes to the RUC for review: 1) the codes have been taken off of the -51 modifier xempt list; and 2) the codes have never been reviewed as 90-day globals and were part of a review of ɔRIF codes. Below is a history of database information for each code:

History 20690:

In the Harvard submission to CMS in March 1992 (preliminary phase 3D data), code 20690 was studied as a 090-day global code with a vignette of "Application of external fixation system (eg, Hoffman)". The recorded times were 32/80/20 (pre/intra/post), 2 hospital, and 4 office visits. Total Harvard time was 206 minutes and total Harvard work was 481 (or 4.90 scaled to the MFS).

The 1992 MFS published RVW was 3.71 with a ZZZ global period. [From Harvard, this code had a final "pack" or global designation of "sss" which denotes a secondary code (usually billed in addition to another service).]

In 1999, the Harvard times (noted above) were discarded and a predicted total time of 99 minutes was implemented for practice expense purposes.

From 1992 to 1999(interim), the global period was ZZZ. In 1998, the RVW was 3.52.

Additional sources confirm a ZZZ global period through 1998. In 1997, the CPEP(3) data list zero for post-op visits. Also, in 1997, Dan Dunn's file submission to CMS regarding increases in the payment for 'obal services due to the increase in EM services after the first 5YR, listed this code as having a ZZZ ,obal period.

From 1999(final) to present, the global period is 090. In 2007, the RVW is 3.67. No explanation was provided in any Fed Reg text about this change.

History 20692:

In the Harvard submission to CMS in March 1992 (preliminary phase 3D data), code 20692 was studied a 090-day global code with a vignette of "Applic. of a multiplane, unilat., ext fixation syst". The only recorded time was 114 minutes for intra time and Harvard intra work was presented as 392.

The 1992 MFS published RVW was 6.76 with a ZZZ-day global period. [From Harvard, this code had a final "pack" or global designation of "sss" which denotes a secondary code (usually billed in addition to another service).]

In 1999, the Harvard times (noted above) were discarded and a predicted total time of 159 minutes was calculated for practice expense purposes.

From 1992 to 1999(interim), the global period was ZZZ. In 1998, the RVW was 6.41.

Additional sources confirm a ZZZ global period through 1998. In 1997, the CPEP(3) data list zero for post-op visits. Also, in 1997, Dan Dunn's file submission to CMS regarding increases in the payment for global services due to the increase in EM services after the first 5YR, listed this code as having a ZZZ global period.

From 1999(final) to present, the global period is 090. In 2007, the RVW is 6.40. No explanation was provided in any Fed Reg text about this change.

Given this history, it is clear that the current values and time information are not related to a code with a 90-day global period. Additionally, it is clear that these codes have never been properly reviewed and hav values that are based on prediction.

RATIONALE FOR RECOMMENDATION:

In response to the CPT changes and a request by the RUC and CMS, A survey was sent to orthopaedic surgeons representing general orthopaedics, trauma, and foot and ankle surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services. The panel agreed that both 20960 and 20962 can be performed as a stand alone code for fixation of a fracture or deformity and therefore should correctly have a global period of 90-days. Further, the panel agreed that the current values for the codes are not based on 90 days of care.

20690: The panel compared 20690 to two equally cited key reference codes 24566 (Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation) and 25606 (Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation). The typical patient requiring 20690 will likely be a trauma victim and will required admission to the hospital, with greater postoperative work compared to the reference codes. The survey median RVW of 11.00 (IWPUT=0.056) is recommended. This value correctly sets 20690 greater than the reference codes, taking into consideration the significant postoperative work for these patients.

20692: The panel compared 20692 to key reference code 27447 (total knee). The intra-service times an hospital visits are similar for both codes, however, 20692 would require significantly more office visi The survey median RVW of 21.00 (IWPUT=0.069) is recommended. This value correctly sets 20692 less than 27447 because the panel felt that the greater intensity of 27447 outweighed the additional office visits for 20692.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20692

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

Specialty ortho How often? Sometimes

Specialty podiatry How often? Sometimes

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,600 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. database

Specialty ortho Frequency 1200 Percentage 75.00 %

Specialty podiatry Frequency 352 Percentage 22.00 %

Specialty others Frequency Percentage %

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

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 20664 Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia (Work RVU=9.86) as this procedure was used as a alternative reference code in valuing 20692.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

CPT Code:_____

Specialty Society('s)_____

CPT Code: 20690, 26092

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

20690: Application of a uniplane (pins or wires in one plane), unilateral, external fixation system

20692: Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

Standard times for the activities necessary in the office and 100% of physician time were applied.
The standard 12 minutes has been applied for the inpatient procedure for discharge day management services from the facility.

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E	F	G
1				20690 (R1)		20692 (R2)	
2	Meeting Date: April 2007			Application of a uniplane (pins or wires in one plane), unilateral, external fixation system		Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90	N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	111	N/A	288
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	99	N/A	216
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA				5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA				20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA				8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				7
17	**End: When patient enters office/facility for surgery/procedure**						
18	SERVICE PERIOD						
19	**Start: When patient enters office/facility for surgery/procedure**						
20	**Pre-service services**						
21	Review charts						
22	Greet patient and provide gowning						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure						
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	/coordinate office visits /prescriptions						
39	Discharge day management 99238 –12 minutes 99239 –15 minutes	L037D	RN/LPN/MTA		12		12
41	**End: Patient leaves office/FACILITY**						
42	POST-SERVICE PERIOD						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27		1		4
49	99213 36 minutes	L037D	36		2		3
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53							
54	*Total Office Visit Time*			0	99	0	216
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				20690 (R1)		20692 (R2)	
2	Meeting Date: April 2007			Application of a uniplane (pins or wires in one plane), unilateral, external fixation system		Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
57	[illegible]	[illegible]	[illegible]				
58	pack, minimum multi-specialty visit	SA048	pack		3		7
59	pack, post-op incision care (suture)	SA054	kit				
60	drape, sterile, three-quarter sheet	SB014	item				
61	gloves, non-sterile	SB022	pair				
62	underpad 2ft x 3ft (Chux)	SB044	item				
63							
64							
65							
66	[illegible]	[illegible]	[illegible]				
67	table, power	EF031	100%		99		251
68	light, exam	EQ168	100%		99		251
69	computer related eqiupment-2069X1/X2 (will provide underseparate cover)						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Computer Navigation

The CPT Editorial Panel created three new Category I CPT codes in February 2007 to replace three Category III CPT codes used to describe computer assisted navigation for musculoskeletal surgical procedures. Since the establishment of the Category III codes, adequate evidence on the improved results with this technology have been published to warrant the conversion of these codes to Category I codes. The Panel also concluded that an add-on code was necessary to describe this extra effort since the use of this technology requires additional physician work, complexity and time beyond that normally involved in a musculoskeletal procedure.

20985

The RUC considered the specialty society survey results and presentation for CPT code 20985, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less*. The RUC reviewed the survey results in comparison to the key reference service code 22522, *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)*, (work RVU = 4.30, intra-time = 50 minutes). The reference service code has significantly more intra-service time, 50 minutes compared to 20 minutes; however, the surveyed code requires much greater mental effort and judgment as well as technical skill and physical effort. Based on this comparison, the RUC agreed that the 25th percentile of the survey results (work RVU = 2.50), slightly more than half the work RVU of the reference service, was appropriate. The RUC agreed with the specialty society's recommendation of 10 minutes of pre-time, despite the fact that the service will be reported as a ZZZ global period, add-on procedure. Typically, ZZZ codes contain no pre- or post-service time. The presenters noted that 20985 differed from other add-on services with respect to pre-time because of the significant time and effort required to initiate and calibrate computer navigation equipment as well as additional patient positioning time for the computer navigation to be used. However, as an add-on procedure, the RUC disagreed with the specialty society's recommendation to include five minutes of post-service time. The time was considered duplicative of any post-time which would be included in the procedure codes reported with code 20985. The time was revised to pre-service time of 10 minutes, intra-service time of 20 minutes and post-service time of zero minutes for CPT code 20985.

The RUC recommends a work RVU of 2.50 for CPT code 20985.

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The RUC recommends no practice expense inputs for this add-on code.

The RUC also noted that the service used for professional liability insurance (PLI) crosswalk for CPT code 20985 (CPT code 22522) has a work RVU of nearly twice its recommended work RVU. As such, the RUC recommended a more appropriate PLI reference service, 22103, *Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)*, (work RVU = 2.34).

20986

The RUC considered the specialty society survey results and recommendations for CPT code 20986, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less; with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound).* Because of the low response rate (n = 21) and the service performance rate (median = 0), the RUC concluded that the survey results were unreliable and could not make an appropriate recommendation of physician work based on these data. As such, the RUC agreed that the service should be interim valued as carrier priced and requested that the specialty society re-survey CPT code 20986 for the September 2007 RUC meeting.

The RUC recommends that CPT code 20986 be interim valued as carrier priced.

20987

The RUC considered the specialty society survey results and recommendations for CPT code 20987, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less; with image-guidance based on pre-operative images (eg, CT, MRI).* Because of the low response rate (n = 21) and the service performance rate (median = 0), the RUC concluded that the survey results were unreliable and could not make an appropriate recommendation of physician work based on these data. As such, the RUC agreed that the service should be interim valued as carrier priced and requested that the specialty society re-survey CPT code 20987 for the September 2007 RUC meeting.

The RUC recommends that CPT code 20987 be interim valued as carrier priced.

New Technology

Because of the new codes were developed from Category III CPT codes, the low survey response rates, and at the request of the specialty society, **the RUC recommends codes 20985, 20986, and 20987 be added to the New Technology list.**

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+●20985	S1	Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	ZZZ	2.50
+●20986	S2	with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound), (List separately in addition to code for primary procedure) (If multiple imaging modalities are used, report 20986 only once) (Do not separately report intra-operatively obtained images)	ZZZ	Carrier Priced (Interim)
+●20987	S3	with image-guidance based on pre-operative images (eg, CT, MRI), (List separately in addition to code for primary procedure) (If multiple imaging modalities are used, report 20987 only once) (Do not report codes 20985-20987 with 61795)	ZZZ	Carrier Priced (Interim)
Category III				
D +0054T		~~Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)~~		N/A
D +0055T		~~Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)~~ ~~(When CT and MRI are both performed, report 0055T only once)~~		N/A

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D +0056T		~~Computer-assisted musculoskeletal surgical navigational orthopedic procedure, image-less (List separately in addition to code for primary procedure)~~ (0054T-0056T have been deleted. To report see 20985-20987)		N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20985 Tracking Number S1 Specialty Society Recommended RVU: **2.50**
Global Period: ZZZ RUC Recommended RVU: **2.50**

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

CLINICAL DESCRIPTION OF SERVICE:

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

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
ADDITIONAL Pre-service work

At the time of the initial visit, in addition to the standard discussion of total knee replacement, the surgeon spends additional time discussing the use of computer navigation as an adjunct to the total knee procedure. This involves explaining the rationale for the use of the system, how it helps align the knee and that the surgery may be somewhat longer and more complicated. The explanation describes the use of additional small incisions for placement of the pins through the bone along with the additional risks of wound healing issues at the pin sight and the risk of a fracture through one of the pin holes.

- Prior to the surgical procedure and positioning, the computer navigation unit is brought into the room and following booting up of the computer, the surgeon activates the navigation software and enters patient specific information such as identifiers, surgeon, and side of surgery.
- Setup options for the program are checked and adjusted as necessary
- Once the patient has been positioned on the operating table, the navigation unit is moved into place so the intra-operative trackers will be in the field of view of the cameras and the surgeon will be able to see the computer monitor screen

Description of Intra-Service Work: Pins are placed through the tibia and femur to which clamps are attached to hold the trackers that will be used during the surgical procedure. If these are placed outside the intended surgical wound, they are inserted percutaneously through separate stab wounds and engage to one or both cortices. One or two pins may be used on the tibia and femur. If the pins are placed inside the operative wound, the pins are placed after the surgical exposure. Other systems employ small electromagnetic trackers that are also attached to the femur and tibia.
Once the pins are placed, the navigation trackers are secured to them. The trackers may be passive devices with reflective balls whose position is determined by infra-red light signals sent from the camera system which senses their position. They may also be active devices that emit infra-red light signals that are sensed by a camera system. The initial art of the procedure is to register these trackers with the computer navigation system.
ollowing activation and identification of the trackers, the registration process begins with moving the hip in a circular fashion that allows the computer software to identify the center of the sphere created in space which is also the center of the femoral head. Following surgical exposure, the bony landmarks of the femur and tibia are identified individually by directed digitization with a "pointer" device that also has tracker components on it. The landmarks identified are generally the medial epicondyle, the lateral epicondyle, distal femoral center, axis of the femoral trochlear groove, the

surfaces of the medial and lateral distal and posterior condyles and the topography of the medial and lateral anterior distal femur. The tibia is then registered by digitizing the center of the tibial plateau, the anterior-posterior axis of the tibia and the surfaces of the medial and lateral tibial condyles. The ankle center is found by digitizing the tips of the medial and lateral malleoli and the point between them.

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

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

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

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

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

Description of Post-Service Work: NA

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; Richard Wixson, MD				
Specialty(s):	AAOS, OTA, AAOS				
CPT Code:	20985				
Sample Size: 100	**Resp N:** 21	**Response:** 0.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	15.00	**40.00**	100.00	400.00
Survey RVW:	1.40	250.00	**3.50**	405.00	6.25
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	20.00	**20.00**	30.00	60.00
Immediate Post Service-Time:	**5.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x	99292x		

Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
rolonged Services:	0.0	99354x	55x	56x	57x	

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 20985	
	Specialty Recommended
Physician Work RVU:	2.50
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	20.00
Immediate Post Service-Time:	0.00

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

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22522	ZZZ	4.30	RUC Time

CPT Descriptor Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)

	CPT Code: 20985	Key Reference CPT Code: 22522	Source of Time RUC Time
Median Pre-Service Time	10.00	0.00	
Median Intra-Service Time	20.00	50.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**30.00**	**50.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.67
Urgency of medical decision making	4.50	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.33
Physical effort required	4.00	3.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	4.33
Outcome depends on the skill and judgment of physician	4.75	4.67

Estimated risk of malpractice suit with poor outcome	4.25	4.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	3.33
Intra-Service intensity/complexity	4.25	4.00
Post-Service intensity/complexity	1.67	2.00

Additional Rationale

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

A survey was sent to orthopaedic surgeons representing general orthopaedics, trauma, and shoulder & elbow surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services. The panel agreed that this add-on service requires additional pre-and post-service time (as described above) that is distinctly related to this code and not the primary procedure. The survey 25th percentile RVW of 2.50 is recommended. This value correctly sets this new code relatively less than the reference code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) deleted codes 0054T-0056T

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

Specialty AAOS How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Code Requestor

Specialty ortho Frequency 3000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1549 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Medicare Database for relevent T Code

Specialty ortho Frequency 1549 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 22103, Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure) (work RVU = 2.34) because it is comparable in work RVU and specialty.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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

CPT Long Descriptor:

20985 Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey code relative to other facility-only ZZZ global orthopaedic services.

We recommend no clinical labor, supplies, or equipment related to this add-on service.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2006

Temporomandibular Joint Manipulation

The CPT Editorial Panel created a new code category I CPT code, 21073, *Manipulation of temporomandibular joint (TMJ), therapeutic, requiring general anesthesia*, to report an existing service for complex manipulation of the temporomandibular joint that has not been adequately codified in CPT.

The RUC reviewed the specialty society's survey results for new CPT code 21073 and the use of the key reference service code, 21485, *Closed treatment of temporomandibular joint dislocation; complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent* (work RVU = 3.98, total time = 200). Members of the RUC noted that the reference service list included codes with a range of work RVUs of 2.73 - 46.37. It was agreed that a greater number of lower RVU reference services should have been included. Because of this, the RUC agreed that the survey was positively skewed due to overestimation and subsequent magnitude increases by respondents. The resulting overestimations lead to high pre-service time responses and higher RVU estimations than appropriate. In addition, the RUC noted that the pre-service positioning time is too high for the services being provided. As such, the RUC reduced the pre-service positioning time to 5 minutes, reducing the total pre-service time to 25 minutes. Considering all of the above, the committee believed the 25th percentile survey work RVU (3.80) was appropriate for the service.

Additionally, the RUC discussed the post-operative visits and agreed, due to the typical patient as well as the nature of the service, that four follow-up office visits were appropriate. However, the RUC determined that the intensity of the first post-operative visit was too high and recommended that the 99213 visit be reduced to a 99212. The resulting reduction in RVU is 0.47. In summary, correcting for the 25th percentile value (3.80) and subtracting .47 yields a recommended value of 3.33 RVU. **The RUC recommends a relative work value of 3.33 for code 21073 with a pre-service time of 25 minutes.**

Practice Expense
The RUC approved the standard 090 day global direct practice expense inputs. Additionally, the RUC reviewed and accepted the amended practice expense inputs.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●21073	A1	Manipulation of temporomandibular joint (TMJ), therapeutic requiring general anesthesia (For TMJ, manipulation without general anesthesia, see 97140, 98925-98929, or 98943) (Monitored Anesthesia Care (MAC) is considered General Anesthesia) (For closed treatment of temporomandibular dislocation, see 21480, 21485)	090	3.33

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21073 Tracking Number A1 Specialty Society Recommended RVU: **4.15**
Global Period: 090 RUC Recommended RVU: **3.33**

CPT Descriptor: Manipulation of temporomandibular joint (TMJ), therapeutic requiring general anesthesia
(For TMJ, manipulation without general anesthesia, see 97140, 98925-98929, or 98943)
(Monitored Anesthesia Care (MAC) is considered General Anesthesia)
(For closed treatment of temporomandibular dislocation, see 21480, 21485)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old female presents with a long-standing history of clicking and popping of the jaw. For the last 3 months, she has limited opening restricted to 20 mm (normal being 45 mm). She will undergo manipulation of the temporomandibular joint in the office under general anesthesia. (Note: The provision of anesthesia is reported separately).

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Imaging studies are carefully reviewed including x-rays (e.g., orthopantomograph), CT scans, and MRIs. Consultation is completed with the referring physician, dentist, ER department and other healthcare professionals
- The family and patient are apprised of the proposed procedure.
- The risks and complications associated with the procedure are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operatory and verifies that appropriate equipment and supplies are available
- The patient is brought to the operatory and placed onto the operatory unit/table in the semi-recumbent position.
- The position of the head is checked and adjusted.
- The pre-operative findings (range of motion, direction of motion including deviations or deflections, pain with palpation, etc.) are reconfirmed.
- The surgical assistant and surgeon then scrub and dress
- "Time Out" was called for staff and doctor re-verify patient, procedure and procedure site. -

Description of Intra-Service Work: Anesthetize the temporomandibular joint.
Anesthetize the muscles (masseter, temporalis, medial pterygoid, lateral pterygoid) as necessary.
After applying protective layers of gauze around the thumbs and additional gloves, the surgeon enters the oral cavity. Pressure is applied to the posterior mandible bilaterally, keeping the mandible in the retruded position and gradually distracting the condyle inferiorly. The mandible is then simultaneously moved side to side. The surgeon re-establishes appropriate superior joint space translation and inferior joint space translation with this bi-manual maneuvering, the success of which is evaluated by the range of motion and absence of clicking. This is repeated as needed until the maximum range of motion is achieved which is measured and recorded. Post-procedure palpation exam is performed and the findings are recorded.
The pre-fabricated inter-occlusal stabilization splint is then inserted. The new bite is then marked with marking ribbon intra-orally. Adjustments are made with a handpiece, bur and irrigation extra-orally. This is repeated for each opposing oth until all interferences are eliminated and the occlusion is even and stable across the occlusal arch.

Description of Post-Service Work: -- The patient's active interincisal ROM at conclusion is measured; this is a separate evaluation from the intra-procedure evaluation. A custom homecare physical therapy tool is fabricated from tongue depressors. Detailed home care physical therapy instructions are demonstrated to patient and family.

- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and post-manipulation dietary regimen.
- Communication with health care professionals including written and oral reports and orders.
- The patient's vital signs are checked.
- The motor and sensory function of are evaluated and recorded.
- Postoperative imaging studies (orthopantomograph) are obtained and reviewed by the surgeon.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2006					
Presenter(s):	Timothy S. Shahbazian, DDS					
Specialty(s):	Oral and Maxillofacial Surgery					
CPT Code:	21073					
Sample Size:	150	**Resp N:**	33	**Response:** 22.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.76	3.80	**4.15**	7.18	21.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		10.00	15.00	**20.00**	30.00	60.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 21073		
		Specialty Recommended
Physician Work RVU:		**4.15**
Pre-Service Evaluation Time:		**15.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**5.0**
Intra-Service Time:		**20.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**64.0**	99211x **0.0** 12x **4.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
21485	090	3.98	**Harvard Time**

CPT Descriptor Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1 Global Work RVU Time Source

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU Time Source

PT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
21030	090	4.49	**RUC Time**

CPT Descriptor Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curretage

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 54.5 %

TIME ESTIMATES (Median)	CPT Code: 21073	Key Reference CPT Code: 21485	Source of Time Harvard Time
Median Pre-Service Time	30.00	0.00	
Median Intra-Service Time	20.00	0.00	
Median Immediate Post-service Time	20.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	64.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**134.00**	**0.00**	
Other time if appropriate		200.00	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.76	2.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.94	2.77
Urgency of medical decision making	2.59	2.69

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.08
Physical effort required	2.68	2.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.24	2.46
Outcome depends on the skill and judgment of physician	3.00	2.92
Estimated risk of malpractice suit with poor outcome	2.71	2.85

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.88	2.64
Intra-Service intensity/complexity	2.82	2.79
Post-Service intensity/complexity	2.41	2.46

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The reference service code 21485 does not have surveyed time, but "relatively" the new code would require more work. The preservice work for 21073 is very similar to 21030 and 21040, therefore we are suggesting a reduction in pre-service time, broken into the components as shown. 21073 would require additional office visits compared with 21030 and 21040 for range of motion and/or relapse monitoring. The median RVW places 21073 correctly, greater than the RVU for the reference code 21485 and less than the RVU for open procedures 21030 and 21040.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21299 Unlisted craniofacial and maxillofacial procedure

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

Specialty Oral and Maxillofacial Surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 25000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Oral and Maxillofacial Surgery Frequency 25000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Oral and Maxillofacial Surgery Frequency 300 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).

Timothy S. Shahbazian, DDS

AMA/Specialty Society Update Process
PERC Summary of Recommendation
090 Day Global Periods
Non Facility Direct Inputs

CPT Long Descriptor:
Manipulation of temporomandibular joint (TMJ), therapeutic requiring general anesthesia
(For TMJ, manipulation without general anesthesia, see 97140, 98925-98929, or 98943)
(Monitored Anesthesia Care (MAC) is considered General Anesthesia)
(For closed treatment of temporomandibular dislocation, see 21480, 21485)

Sample Size: 150 Response Rate: (%): 22% Global Period: 090

Geographic Practice Setting %: Rural 3% Suburban 50% Urban 47%

Type of Practice %:
44% Solo Practice
41% Single Specialty Group
3% Multispecialty Group
12% Medical School Faculty Practice Plan

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

A consensus panel of physicians from the AAOMS representing a broad mix of categories of type of practice and geographic areas developed direct practice expense details for this procedure code

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The surgical assistant prepares the room and room equipment, lighting suction and supplies needed for the procedures; identifies, greets and escorts the patient to the procedure room; assembles patient chaperone(s) for doctor to apprise them of planned procedure; assembles pre-procedural imaging studies and records; assists in positioning the patient; records findings of immediate pre-procedural examination; scrubs and dresses; participates in "time-out".

Intra-Service Clinical Labor Activities:
During the procedure the surgical assistant prepares local anesthetic and aspirating syringe assembly; applies pressure to injection sites as needed, provides retraction during the procedure for intra-oral access, and provides continuous suction of saliva from the oral cavity. If the doctor is able to successfully manipulate the temporomandibular joint, the assistant will then apply the appropriate digital protection and manipulates the joints while the doctor palpates both joints during translation and rotation to verify adequate movement. For purposes of the splint adjustment the assistant assembles the drill and burs, provides suction and irrigation while the splint is being adjusted intra-orally and/or extra-orally, assembles and changes occlusal marking tape during the adjustment, and provides final polishing for the splint. The assistant records the findings of the immediate post-procedure exam.

Post-Service Clinical Labor Activities:
The surgical assistant removes the patient records and studies used during the procedure, cleans the room, cleans and sterilizes the drill assembly and burs, disposes of used supplies, completes post-procedure imaging requisitions, evaluates condition of local anesthesia injections sites, escorts the patient's family/chaperone to the recovery area, answers questions regarding instructions for home care physical therapy instructions given by the doctor, instructs family/chaperone in wear, removal and hygiene procedures of splint, establishes follow-up appointment.

	A	B	C	D	E
1					
2				21073	
3	Meeting Date: Specialty:			Manipulation of temporomandibular joint, TMJ, therapeutic, requiring general anesthesia	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD				
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MA	198.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	35.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MA	43.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			120.0	0.0
10	PRE-SERVICE				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA	5	
13	Coordinate pre-surgery services	L037D	RN/LPN/MA	10	
14	Schedule space and equipment in facility	L037D	RN/LPN/MA	0	
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	10	
16	Follow-up phone calls & prescnptions	L037D	RN/LPN/MA	10	
17	Other Clinical Activity (please specify)	L037D	RN/LPN/MA		
18	**End:When patient enters office/facility for surgery/procedure**				
19	SERVICE PERIOD				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts	L037D	RN/LPN/MA	2	
23	Greet patient and provide gowning	L037D	RN/LPN/MA	3	
24	Obtain vital signs	L037D	RN/LPN/MA		
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MA		
26	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2	
27	Setup scope (non facility setting only)	L037D	RN/LPN/MA		
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	2	
29	Sedate/apply anesthesia	L037D	RN/LPN/MA	2	
30	**Intra-service**	L037D	RN/LPN/MA		
31	Assist physician in performing procedure	L037D	RN/LPN/MA	20	
32	**Post-Service**	L037D	RN/LPN/MA		
33	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA		
34	Clean room/equipment by physician staff	L037D	RN/LPN/MA	3	
35	Clean Scope	L037D	RN/LPN/MA		
36	Clean Surgical Instrument Package **(drill system only)**	L037D	RN/LPN/MA	4	
37	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MA	2	
38	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MA	1	
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MA	2	
40	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D	RN/LPN/MA		
41	Other Clinical Activity (please specify)	L037D	RN/LPN/MA		
42	**End: Patient leaves office**				
43	POST-SERVICE Period				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MA	3	
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care	L037D	RN/LPN/MA		
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27	3	
50	99213 36 minutes		36	1	
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54					
55	*Total Office Visit Time*			117	0
56	Other Activity (please specify)				
57	**End: with last office visit before end of global period**				

	A	B	C	D	E
2				21073	
3	Meeting Date: Specialty:			Manipulation of temporomandibular joint, TMJ, therapeutic, requiring general anesthesia	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
58	MEDICAL SUPPLIES	CMS Code	Unit		
59	pack, minimum multi-spcialty visit	SA048	5		
60	ruler	NEW	5		
61	tongue depresser	SJ061	54		
62	suction tip, Yankauer	SD122	5		
63	suction canister	SD009	5		
64	tubing, suction, non-latex (6ft) with Yankauer tip	SD134	5		
65	lidocaine 2% w-epi-inj (Xylocaine w-epi)	SH049	6		
66	disposable aspirating syringe	NEW	1		
67	gauze non-sterile 2in X 2in	SG050	6		
68	needles, 18-27g	SC029	1		
69	non-sterile gloves	SB022	1		
70	biteblock	SD0006	2		
71	tape, surgical occlusive 1in (Micropore)	SG079	24		
72	bur, surgical, sterile (drill)	SD142	1		
73	water, sterile for irrigation (250ml)	SH074	1		
74	articulating ribbon	NEW	2		
75	swab-pad, alcohol	SJ053	1		
76	Equipment	CMS Code	Unit		
77	chair with headrest, exam, reclining	EF008	5		
78	light, dental, ceiling mount (Adec)	EF039	5		
79	drill system, surgical, large (Stryker)	EQ106	1		

NOT ENTERED IN RVU Database

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Interstitial Fiducial Marker Placement

The CPT Editorial Panel created three new codes to describe the implantation of fiducial markers, electromagnetic transducers or dosimeters to localize tumors during image-guided radiotherapy in the head or neck, intra-thoracically or intra-abdominally.

The Society of Interventional Radiology (SIR) and American College of Radiology (ACR) surveyed the interstitial fiducial marker placement codes. However, the survey response rates were low, with four to eight respondents per code. SIR indicated that this procedure is rarely performed and does not meet the criteria to be a category I code as being widely performed. The American Society for Therapeutic Radiology and Oncology (ASTRO) representatives indicated that these procedures are performed in conjunction with radiation therapy, particularly SBRT, and the low response rate could likely be attributed the use of a random survey sample that didn't reach the appropriate audience. The RUC was concerned that the CPT coding proposal and RUC testimony on volume were inconsistent. **The RUC agreed that the survey data was not representative and determined that they could not develop work RVU recommendations based on this data. The RUC referred codes 21112, 21520, and 49437 back to CPT. The CPT Executive Committee rescinded these codes for *CPT 2008* and specialty societies will need to submit a new coding proposal to CPT in order to create new Category I CPT codes for interstitial fiducial marker placement.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●21112	T1	~~Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), head or neck (via needle, percutaneous), single or multiple~~ ~~(Report supply of device separately)~~ ~~(For imaging guidance, see 76942, 77002, 77012, 77021)~~	000	Rescinded by CPT Executive Committee
Neck (Soft Tissues) and Thorax **<u>Introduction or Removal</u>**				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●21520	T2	~~Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-thoracic (via needle, percutaneous), single or multiple (with placement of associated thoracic wall markers, when performed)~~ ~~(Report supply of device separately)~~ ~~(For imaging guidance, see 76942, 77002, 77012, 77021)~~ ~~(For placement of interstitial device in the neck radiation therapy guidance, use 21112)~~	000	Rescinded by CPT Executive Committee
Excision *(For bone biopsy, see 20220-20251)*				
21550		*Biopsy, soft tissue of neck or thorax*	010	2.08 (No Change)
Digestive System **Abdomen, Peritoneum, and Omentum** **Introduction, Revision, Removal**				
●49437	T3	~~Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, pelvis (except prostate), or retroperitoneum (via needle, percutaneous), single or multiple~~ ~~(For placement of interstitial devices in the abdominal wall for radiation therapy guidance, use 49999)~~ ~~(Report supply of device separately)~~ ~~(For imaging guidance, see 76942, 77002, 77012, 77021)~~ ~~(For placement of interstitial devices for radiation therapy guidance into the~~	000	Rescinded by CPT Executive Committee

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~prostate, use 55876)~~		
Radiology **Radiologic Guidance** **Computed Tomography Guidance**				
77014		Computed tomography guidance for placement of radiation therapy fields (For placement of interstitial device(s) for radiation therapy guidance, see 21112, 21520, 49437, 55876)	XXX	0.85 (No Change)
Radiation Oncology **Radiation Treatment Delivery**				
77421		Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy (Do not report 77421 in conjunction with 77432, 77435) (For placement of interstitial device(s) for radiation therapy guidance, prostate, use see 21112, 21520, 49437, 55876)	XXX	0.39 (No Change)

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Three Column Osteotomy

In February 2007, the CPT Editorial Panel created three new Category I CPT codes to describe a group of procedures to address osteotomies performed through one column of the spine (the posterior column). Advances in surgical technique, instrumentation and intra-operative hemodynamic management have allowed for osteotomies that go through all three columns to be performed from a posterior approach. Three column osteotomies take significantly more time to perform and are associated with additional risk. Three CPT codes needed to be developed to address more complex deformities and allow greater degrees of correction than single column osteotomies.

22206

The RUC reviewed the specialty societies' survey results and presentation for code 22206, *Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic.* The randomized survey, completed by 80 neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics, was reviewed by an expert panel to ensure accuracy, validity and relativity of the survey results. The specialties and the RUC agree that the survey's median pre-, intra-, and post-service times as well as the post-operative visits required for this intense procedure were accurate. The RUC also reviewed the key reference service selected by nearly half of the survey respondents, 63101, *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment* (work RVU = 33.92). The RUC noted that the reference service contained significantly less intra-service time than the surveyed code, 215 minutes versus 300 minutes, respectively. In addition to this difference with the reference service, the surveyed code requires significantly more intensity and complexity in technical skill, risk of complications, judgment of the physician, and malpractice risk. Based on the quality of the survey data presented and relativity to the key reference service, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 37.00.

The RUC recommends the survey median work RVU of 37.00 for code 22206.

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22207

The RUC reviewed the specialty societies' survey results and presentation for code 22207, *Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); lumbar.* The randomized survey, completed by 80 neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics, was reviewed by an expert panel to ensure accuracy, validity and relativity of the survey results. The specialties and the RUC agree that the survey's median pre-, intra-, and post-service times as well as the post-operative visits required for this intense procedure were accurate. The RUC also reviewed the key reference service selected by more than half of the survey respondents, 63087, *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment* (work RVU = 37.38). The RUC noted that the reference service contained less intra-service time than the surveyed code, 265 minutes versus 300 minutes. Additionally, the surveyed code requires only slightly more mental effort and judgment, technical skill, physical effort, psychological stress, and intensity/complexity per time segment than the reference service. Based on the quality of the survey data presented and relativity to the key reference service, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 36.50.

The RUC recommends the survey median work RVU of 36.50 for code 22207.

104

22208

The RUC reviewed the specialty societies' survey results and presentation for code 22208, *Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to primary procedure).* The RUC also reviewed the key reference service, 22216, *Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)*, (work RVU = 6.03), in relation to the surveyed code and noted that the reference service required only half of the intra-service time, 60 minutes versus 120 minutes. In addition to the broad difference in time, the surveyed code also requires greater intensity and complexity to perform. The RUC agreed that the median work RVU from the specialty societies' survey, compared to the key reference service, was justified. However, as an add-on service with a global period of ZZZ, the RUC found there to be duplicative work described in the pre-service and intra-service times. The presenters agreed with the RUC regarding pre-time and recommended a reduction in the work RVUs consistent with the duplicative time accounted for in the pre-service period. Using an IWPUT calculation or building block methodology, the RUC backed-out the work RVUs associated with the 15 minutes of pre-service time originally proposed by the specialty and removed the 15 minutes from the service. Multiplying the time by the intensity associated with pre-service time (10 minutes of pre-service evaluation time at 0.0224 and 5 minutes of pre-service positioning time also at 0.0224), resulted in a reduction of 0.34 work RVUs [15 minutes x 0.0224 = 0.34] from the survey median RVU, accounting for a recommended work RVU of 9.66 [10.00

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– 0.34 = 9.66]. The RUC recommends a pre-service time of 0 minutes, intra-service time of 120 minutes, and immediate post-service time of 15 minutes.

The RUC recommends a work RVU of 9.66 for code 22208.

Practice Expense

The RUC recommends the practice expense inputs as amended by the PERC in the facility setting for 22206-22208, removing duplicative clinical staff time in the pre-service period.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
To report arthrodesis... *To report instrumentation procedures...* *To report bone graft...* *For the following codes...* Spinal osteotomy procedures are reported when (a) portion(s) of the vertebral segment(s) is cut and removed in preparation of re-aligning the spine as part of a spinal deformity correction. For excision of an intrinsic lesion of the vertebra without deformity correction, see 22100-22116. For decompression of the spinal cord and/or nerve roots, see 63001-63308. The three columns are defined as: anterior (anterior two-thirds of the vertebral body), middle (posterior third of the vertebral body and the pedicle), and posterior (articular facets, lamina and spinous process)				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●22206	U1	Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic (Do not report 22206 in conjunction with 22207)	090	37.00
●22207	U2	lumbar (Do not report 22207 in conjunction with 22206)	090	36.50
+●22208	U3	each additional vertebral segment (List separately in addition to primary procedure) (Use 22208 in conjunction with 22206, 22207) (Do not report 22206, 22207, 22208 in conjunction with 22210-22226, 22830, 63001-63048, 63055-63066, 63075-63091, 63101-63103, when performed at the same level)	ZZZ	9.66

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22206 Tracking Number U1 Specialty Society Recommended RVU: **37.00**
Global Period: 090 RUC Recommended RVU: **37.00**

CPT Descriptor: Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman presents with persistent disabling spine pain and progressive spinal deformity. Non-operative therapy is unsuccessful. Examination documents loss of normal sagittal and/or coronal alignment. Imaging studies confirm the presence of thoracic kypho-scoliosis.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The medical record is reviewed and the history is updated to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed and the site of the osteotomy and the amount of correction required is planned. The surgeon confers with the patient and family; explaining the current condition and planned surgery. Questions are answered, consent is obtained and a note written in the record. The surgeon confers with the anesthesiologist, the neurophysiologist for intraoperative monitoring, cell saver blood collection personnel, the representative from the implant company, and the operating room staff to review positioning, the intraoperative plan and equipment needs. The surgical site is marked. Images are hung in the operating room. The patient is anesthetized and is positioned prone on the operating room table. The surgeon scrubs and the surgical site is prepped and draped into a sterile field.

Description of Intra-Service Work: Local anesthetic is infiltrated at the incision site. Incision is made through the skin and subcutaneous tissue. Dorsal fascia is incised and subperiosteal dissection is carried out along the spinous process, lamina, transverse processes, and rib heads exposing T10, T11, and T12. The appropriate level is marked and checked with imaging (x-ray or fluoroscopy). A T10, T11, and T12 laminectomy is performed. Bilateral T10-11 and T11-12 complete facetectomy is performed exposing and decompressing T10, T11, and T12 bilaterally. Bilateral T11 pedicle resection is performed. Proximal rib is resected bilaterally. Bone wax is applied to the bony surfaces. The T11 nerve root is retracted medially while a posterior wedge of vertebral body is resected. This is then repeated from the contralateral side of the spine. The end plates are preserved. Deformity correction is then performed and assessed with intraoperative imaging (x-ray or fluoroscopy). Hemostasis is achieved and copious irrigation is used. Additional decompression or osteotomies if required at separate levels may be performed (coded separately). . Arthrodesis and instrumentation may be performed (coded separately). An image is taken to document final alignment. Intraoperative neurophysiological monitoring is repeatedly examined throughout the case (coded separately). Local anesthetic is used to infiltrate the paraspinal musculature and the subcutaneous tissue. Sufascial drain is placed. The wound is then closed in layers and a dressing is placed.

Description of Post-Service Work: The patient is placed on the stretcher and assessed neurologically once awake. The patient is then taken to the recovery room. The surgeon calls the family and describes the findings at operation and answers their questions. Post operative orders are written and a note is dictated. The surgeon maintains contact with ICU staff. During the postoperative hospitalization, the patient is examined for neurologic function. The dressing is inspected and changed as needed. Drain output (if inserted), fluid balance, postoperative laboratory values are reviewed and blood transfusion is ordered if needed. Postoperative X-rays are reviewed showing the alignment of the spine. A physiotherapy and/or physiatry consultation are requested. The referring physician is contacted and informed about the

results of surgery. Daily visits are made while on the hospital floor. The drain tube and the Foley catheter are removed when appropriate, and the wound is inspected and the dressing changed. Activity parameters are modified to advance the patient's ambulation and mobility. The patients diet is advanced as tolerated. Questions from the physiotherapy staff are answered. Daily notes are written documenting the in-hospital progress. Calls are made to arrange for physiothera- visits after discharge. Discharge summary is dictated and prescriptions are provided.

After discharge, the patient returns to the office for suture removal and wound check. Questions regarding physiotherapy and activity levels are answered. Phone calls are answered concerning pain levels and activity restrictions. Subsequent follow-up office visits are schedule to review activity levels and physiotherapy. X-rays of the spine are ordered and reviewed showing the alignment of the spine. Prescription medication refills are reviewed and written. An exercise program is recommended and printed material regarding therapy is provided to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Frederick Boop, MD; John Wilson, MD, Robert Blasier, MD, Claire Tibiletti, MD					
Specialty(s):	AANS, CNS, AAOS, NASS					
CPT Code:	22206					
Sample Size:	250	**Resp N:**	80	**Response:** 32.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	4.00	20.00
Survey RVW:		20.00	32.24	**37.00**	42.00	60.00
Pre-Service Evaluation Time:				**80.0**		
Pre-Service Positioning Time:				**30.0**		
Pre-Service Scrub, Dress, Wait Time:				**20.0**		
Intra-Service Time:		90.00	218.00	**300.00**	360.00	660.00
Immediate Post Service-Time:	**45.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**160.0**	99231x **2.0** 99232x **3.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

lowever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 22206		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		0.00
Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

s the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63101	090	33.92	RUC Time

CPT Descriptor Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 33 **% of respondents:** 41.2 %

TIME ESTIMATES (Median)

	CPT Code: 22206	Key Reference CPT Code: 63101	Source of Time RUC Time
Median Pre-Service Time	130.00	130.00	
Median Intra-Service Time	300.00	215.00	
Median Immediate Post-service Time	45.00	43.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	160.0	160.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**758.00**	**671.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.31	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	4.32
Urgency of medical decision making	3.31	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	4.83
Physical effort required	4.78	4.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.81	4.72
Outcome depends on the skill and judgment of physician	4.78	4.66

Estimated risk of malpractice suit with poor outcome	4.61	4.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.36	4.14
Intra-Service intensity/complexity	4.86	4.86
Post-Service intensity/complexity	4.08	4.08

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
A survey was sent by AANS/CNS, NASS and AAOS to neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics. A consensus panel of experts representing neurosurgery, orthopaedics and spine surgery reviewed the survey data compared with the reference code and other orthopaedic and podiatric services. The urvey had a large number of respondents, 80, and tight ranges for RVW and times.

The panel felt the median RVW of 37.00 and intra-service time of 300 minutes were both accurate. The panel felt that the most commonly cited reference code, 63101 provided a good reference in that 22206 takes more time but is less intense than 63101. Thus we recommend the survey median RVW of 37.00 as the correct value for this procedure. We believe this maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family, particularly the lumbar code which is slightly less intense than the thoracic code and appropriately valued slightly less. The panel felt the survey recommended times for 22206 are all appropriate and accurate and that six post-operative days included a full day discharge (99238) and four post-operative office visits are typical for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

	CPT Code	Global Period	RVW	Pre-Service	Intra-Service	Post-Service
3.	222X6	90	37	130	300	45
4.	22610-51	90	8.54	44	75	69
5.	22614	zzz	6.43		40	
6.	22614	zzz	6.43		40	
7.	22614	zzz	6.43		40	
8.	22842	zzz	12.56		105	
	Total		77.39	174	600	114

9.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT Code 22212 or unlisted 22899.

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

Specialty Neurosurgery How often? Rarely

Specialty Orthopaedics How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. 22212 or 22899 unlisted were two likely methods of reporting. For those reported as 22212, this had a Medicare frequency reported in the RUC data base of approximately 200 cases per year. Of this we estimate fewer than half of those cases will now be described by 222X6. We also estimate that the Medicare population will comprise approximately 50 % of the patient population who undergo 222X6.

Specialty Neurosurgery Frequency 66 Percentage 33.00 %

Specialty Orthopaedics Frequency 134 Percentage 67.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see above rationale

Specialty Neurosurgery Frequency 33 Percentage 33.00 %

Specialty Orthopaedics Frequency 67 Percentage 67.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. CPT Code 22804 is more appropriate because it is also a posterior spine approach and defiinitive procedure code specifically for treatment of spinal deformity with orthopaedic predominance and similar times.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22207 Tracking Number U2 Specialty Society Recommended RVU: **36.50**
Global Period: 090 RUC Recommended RVU: **36.50**

CPT Descriptor: Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); lumbar

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man presents with persistent disabling spine pain and progressive spinal deformity. Non-operative therapy is unsuccessful. Examination documents loss of normal sagittal and/or coronal alignment. Imaging studies confirm the presence of thoraco-lumbar scoliosis and kyphosis.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The medical record is reviewed and the history is updated to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed and the site of the osteotomy and the amount of correction required is planned. The surgeon confers with the patient and family; explaining the current condition and planned surgery. Questions are answered, consent is obtained and a note written in the record. T surgeon confers with the anesthesiologist, the neurophysiologist for intraoperative monitoring, the cell saver blc collection team, the representative from the implant company and the operating room staff to review positioning, the intraoperative plan and equipment needs. The surgical site is marked. Images are hung in the operating room. The patient is anesthetized and is positioned prone on the operating room table. The surgeon scrubs and the surgical site is prepped and draped into a sterile field.

Description of Intra-Service Work: Local anesthetic is infiltrated at the incision site. Incision is made through the skin and subcutaneous tissue. Dorsal fascia is incised and subperiosteal dissection is carried out along the spinous process, lamina, and transverse processes exposing L2, L3, and L4. The appropriate level is marked and checked with imaging (xray or fluoroscopy). A L2, L3, and L4 laminectomy is performed. Bilateral L2-3 and L3-4 complete facetectomy is performed exposing and decopmpressing L2, L3, and L4 bilaterally. Bilateral L3 pedicle resection is performed. Bone wax is applied to the bony surfaces. The L3 nerve root is retracted medially while a posterior wedge of vertebral body is resected. This is then repeated from the contralateral side of the spine. The end plates are preserved. Deformity correction is then performed and assessed with intraoperative imaging (xray or fluoroscopy). Hemostasis is achieved and copious irrigation is used. Additional decompression or osteotomies if required at separate levels may be performed (coded separately). Arthrodesis and instrumentation may be performed (coded separately). An image is taken to document final alignment. Local anesthetic is used to infiltrate the paraspinal musculature and the subcutaneous tissue. A subfascial drain is placed. The wound is then closed in layers and a dressing is placed.

Description of Post-Service Work: The patient is placed on the stretcher and assessed neurologically once awake. The patient is then taken to the recovery room. The surgeon calls the family and describes the findings at operation and answers their questions. Post operative orders are written and a note is dictated. The surgeon maintains contact with ICU staff. During the postoperative hospitalization, the patient is examined for neurologic function. The dressing inspected and changed as needed. Drain output (if inserted), fluid balance, postoperative laboratory values are review and blood transfusion is ordered if needed. Postoperative X-rays are reviewed showing the alignment of the spine. A physiotherapy and physiatry consultation is requested. The referring physician is contacted and informed about the results of surgery. Daily visits are made while on the hospital floor. The drain tube and the Foley catheter are removed when appropriate, and the wound is inspected and the dressing changed. Activity parameters are modified to advance the

patient's ambulation and mobility. The patient's diet is advanced as tolerated. Questions from the physiotherapy staff are answered. Daily notes are written documenting the in-hospital progress. Calls are made to arrange for physiotherapy visits after discharge. A discharge summary is dictated and prescriptions are written.

After discharge, the patient returns to the office for suture removal and wound check. Questions regarding physiotherapy and activity levels are answered. Phone calls are answered concerning pain levels and activity restrictions. Subsequent follow-up office visits are schedule to review activity levels and physiotherapy. X-rays of the spine are ordered and reviewed showing the alignment of the spine. Prescription medication refills are reviewed and written. An exercise program is recommended and printed material regarding therapy is provided to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Frederick Boop, MD; John Wilson, MD, Robert Blasier, MD, Claire Tibiletti, MD					
Specialty(s):	AANS, CNS, AAOS, NASS					
CPT Code:	22207					
Sample Size:	250	**Resp N:** 80	**Response:** 32.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**3.00**	6.00	40.00
Survey RVW:		20.00	32.88	**36.50**	41.25	60.00
Pre-Service Evaluation Time:				**80.0**		
Pre-Service Positioning Time:				**30.0**		
Pre-Service Scrub, Dress, Wait Time:				**20.0**		
Intra-Service Time:		90.00	210.00	**300.00**	360.00	660.00
Immediate Post Service-Time:	**45.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**160.0**	99231x **2.0** 99232x **3.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in following table, and tab through to the new technology/service box.

CPT Code: 22207		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		0.00
Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63087	090	37.38	RUC Time

CPT Descriptor Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
63101	090	33	216	RUC Time

CPT Descriptor 1 Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segmen

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

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

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

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

TIME ESTIMATES (Median)

	CPT Code: 22207	Key Reference CPT Code: 63087	Source of Time RUC Time
Median Pre-Service Time	130.00	105.00	
Median Intra-Service Time	300.00	265.00	
Median Immediate Post-service Time	45.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	160.0	160.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**758.00**	**682.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.34	4.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	4.32
Urgency of medical decision making	4.39	3.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.90	4.66
Physical effort required	4.71	4.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.83	4.63
Outcome depends on the skill and judgment of physician	4.76	4.74

Estimated risk of malpractice suit with poor outcome	4.57	4.66

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.33	4.16
Intra-Service intensity/complexity	4.93	4.56
Post-Service intensity/complexity	4.05	4.06

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
A survey was sent by AANS/CNS, NASS and AAOS to neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics. A consensus panel of experts representing neurosurgery, orthopaedics and spine surgery reviewed the survey data compared with the reference code and other orthopaedic and podiatric services. The survey had a large number of respondents, 80, and tight ranges for RVW and times.

The panel felt the median RVW of 36.50 and intra-service time of 300 minutes were both accurate. The panel felt that the most commonly cited reference code, 63087 provided a solid reference in that 22207 takes slightly more time and less intense than 63087. Thus we recommend the survey median RVW of 36.50 as the correct value for this procedure. We believe this maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family, particularly the thoracic code which is slightly more intense than the lumbar code and appropriately valued slightly higher. The panel felt the survey recommended times for 22207 are all appropriate and accurate and that six post-operative days included a full day discharge (99238) and four post-operative office visits are typical for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

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

	CPT Code	Global Period	RVW	Pre-Service	Intra-Service	Post-Service
3.	222X7	90	36.50	130	300	45
4.	22612-51	90	11.69	47.5	75	15
5.	22614	zzz	6.43		40	
6.	22614	zzz	6.43		40	
7.	22614	zzz	6.43		40	
8.	22842	zzz	12.56		105	
	Total		80.04	177.5	600	60

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22214 or unlisted code 22899

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

Specialty Neurosurgey How often? Rarely

Specialty Orthopaedic How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 22214 or the unlisted code 22899 were previously used to report this service. Code 22214, had a Medicare frequency reported in the RUC data base of approximately 1000 cases per year. Of this we estimate fewer than 25% of those cases would noe be described by 222X7.. We also estimate that the Medicare population will comprise approximately 50 % of the patient population who undergo 222X7.Additionally in the RUC database the proportionate distrubution per specialty is 75% Orthopaedics and 25% Neurosurgery.

Specialty Neurosurgery Frequency 125 Percentage 25.00 %

Specialty Orthopaedics Frequency 375 Percentage 75.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see rationale above

Specialty Neurosurgery Frequency 62 Percentage 24.80 %

Specialty Orthopaedics Frequency 183 Percentage 73.20 %

Specialty Frequency Percentage %

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

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. CPT Code 22804 is more appropriate because also a posterior spine deformity code with orthopaedic predominance and similar times.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22208 Tracking Number U3 Specialty Society Recommended RVU: **9.66**
Global Period: ZZZ RUC Recommended RVU: **9.66**

CPT Descriptor: Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old woman presents with persistent disabling spine pain and progressive spinal deformity. Non-operative therapy is unsuccessful.
Examination documents loss of normal sagittal and/or coronal alignment.
Imaging studies confirm the presence of thoraco-lumbar scoliosis and severe kyphosis.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The existing incision is extended through the skin and subcutaneous tissue. Dorsal fascial incision is extended and subperiosteal dissection is carried out along the spinous process, lamina, and transverse processes exposing the adjacent levels (T12, L1). The appropriate level is marked and checked with imaging (x-ray or fluoroscopy). Additional laminectomies (T12, L1) are performed. Bilateral additional complete facetectomies (T12-L1, L1-2) are performed exposing and decopmpressing the adjacent nerve roots (T12, L1) bilaterally. Bilateral (L1) pedicle resection is performed. Bone wax is applied to the bony surfaces. The (L1) nerve root is retracted medially while a posterior wedge of vertebral body is resected. This is then repeated from the contralateral side of the spine. The end plates are preserved. Deformity correction is then performed and assessed with intraoperative imaging (x-ray or fluoroscopy). Hemostasis is achieved and copious irrigation is used. Additional decompression at other levels may be performed (coded separately). Arthrodesis and instrumentation may be performed (coded separately).

Description of Post-Service Work: Physician checks for and corrects coagulopathy, and checks Ca/Mg levels, as increased coaguloapthy is a risk with additional levels. Communication with the consultant hematologist and blood bank is performed to correct blood and coagulation product deficits. The patient is likely to remain intubated postoperatively as a consequence of the prolonged surgery and significant fluid replacements. Ventilatory management will be instituted by the surgeon or in conjunction with an intensivist or pulmonologist. Diuresis is often required to facilitate extubation by the following morning, particularly if additional blood or coagulation products are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Frederick Boop, MD; Robert Blasier, MD, Claire Tibiletti, MD		
Specialty(s):	AANS, CNS, AAOS, NASS		
CPT Code:	22208		
Sample Size:	250	**Resp N:** 45	**Response:** 18.0 %
Sample Type:	Random		

CPT Code: 22208

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	1.00	**2.00**	4.00	15.00
Survey RVW:		4.82	8.00	**10.00**	16.00	27.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		40.00	90.00	**120.00**	240.00	600.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

lowever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 22208		
		Specialty Recommended
Physician Work RVU:		9.66
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

s the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22216	ZZZ	6.03	RUC Time

CPT Descriptor Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

63103 ZZZ 4.82 **RUC Time**

CPT Descriptor Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic lumbar, each additional segment (List separately in addition to code for primary procedure)

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

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 35.5 %

TIME ESTIMATES (Median)	CPT Code: 22208	Key Reference CPT Code: 22216	Source of Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	120.00	60.00	
Median Immediate Post-service Time	15.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**135.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.38	4.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	4.15
Urgency of medical decision making	3.15	3.15
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.92	4.77
Physical effort required	4.62	4.46
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.62	4.60

Outcome depends on the skill and judgment of physician	4.69	4.50
Estimated risk of malpractice suit with poor outcome	4.77	4.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.31	4.00
Intra-Service intensity/complexity	4.85	4.40
Post-Service intensity/complexity	3.85	3.50

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
A survey was sent by AANS/CNS, NASS and AAOS to neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics. A consensus panel of experts representing neurosurgery, orthopaedics and spine surgery reviewed the survey data compared with the reference code and other orthopaedic and podiatric services. The survey had a large number of respondents with experience with the procedure of 45.

The panel felt the median RVW from the survey respondents of 10.00 and intra-service time of 120 minutes were both accurate for this add-on code. The panel felt that the most commonly cited reference code, 22216 provided a solid reference in that 22208 takes more time (including 15 minutes pre-time for this add-on procedure that is for patient evaluation and consultation prior to the surgery) and more intense than 22216. Thus we recommend the survey median RVW of 10.00 as the correct value for this procedure. We believe this maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family which are the parent codes for this procedure. The panel felt the survey recommended times for 22208 are all appropriate. 15 minutes pre-service time was justified for additional consultation, x-ray review and surgical planning given the additional risk and complexity associated with performing an additional level for this procedure, particularly with respect to hematology consultation, preoperative discussion of blood transfusion risks, arrangement of autologous or directed-donor blood, and preparation of the blood bank for the expected transfusion needs. Additional 15 minutes of post service time is required because the patients are more complex due to the additional surgical time and blood loss associated with the addition of a level to the base procedure. In addition, fluid management including diuresis and ventilatory management are commonly required. The panel felt that it would be extremely rare that this procedure would be performed at more than two levels as the surgical morbidity increases significantly with each additional level.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

	CPT Code	Global Period	RVW	Pre-Service	Intra-Service	Post-Service
3.	222X8	zzz	10	15	120	15
4.	222X6	90	37	130	300	45
5.	22610-51	90	8.24	44	75	69
6.	22614	zzz	6.43		40	
7.	22614	zzz	6.43		40	
8.	22614	zzz	6.43		40	
9.	22842	zzz	12.56		105	
10.						
	Total		87.09	189	690	129

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22216

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

Specialty Orthopaedic Surgery How often? Rarely

Specialty Neurosurgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 140
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. 222X8 is an add-on code that will only be coded with 222X6or 222X7. W estimate that no more than 20% of the total number of procedures performed for 222X6 and 222X7 will be done with an additional level< with the additional level utilizing 222X8. This estimate and the breakdown of percentages of orthopaedics and neurosurgery from the ruc database are the basis for our frequency estimates.

Specialty Orthopaedic Surgery Frequency 98 Percentage 70.00 %

Specialty Neurosurgery Frequency 42 Percentage 30.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 70
If this is a recommendation from multiple specialties pleas[illegible] estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. see above and we estimate this procedure will be done half as frequently in the medicare population.

Specialty Neurosurgery	Frequency 21	Percentage 30.00 %
Specialty Orthopaedics	Frequency 49	Percentage 70.00 %
Specialty	Frequency 0	Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 22842

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor: Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic

Sample Size:__250____ Response Rate: (%):___33___Global Period:_____

Geographic Practice Setting %: Rural__10__ Suburban__40___ Urban___50__

Type of Practice %: __17___Solo Practice
_40____Single Specialty Group
_____ Multispecialty Group
___43__Medical School Faculty Practice Plan

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

. ıease describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms

Coordinate pre-surgery services

Schedule space and equipment in facility

Provide pre-service education/obtain consent

Follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

Discharge day management 99238

Post-Service Clinical Labor Activities:

Telephone calls and prescription management

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor: Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); lumbar

Sample Size:__250____ Response Rate: (%):___33___Global Period:_____

Geographic Practice Setting %: Rural___10 Suburban____40_ Urban__50___

Type of Practice %: __17___Solo Practice
__40___Single Specialty Group
_____Multispecialty Group
___43__Medical School Faculty Practice Plan

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms

Coordinate pre-surgery services

Schedule space and equipment in facility

Provide pre-service education/obtain consent

Follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

Discharge day management 99238

Post-Service Clinical Labor Activities:
Telephone calls and prescription management

AMA/Specialty Society Update Process
PERC Summary of Recommendation
ZZZ Day Global Period
Facility Direct Inputs

CPT Long Descriptor: Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to primary procedure)

Sample Size:_250_____ Response Rate: (%):___18___Global Period:____zzz_

Geographic Practice Setting %: Rural__10__ Suburban___40__ Urban____50_

Type of Practice %: ___17__Solo Practice
___40__Single Specialty Group
_____Multispecialty Group
___43__Medical School Faculty Practice Plan

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

ultispecialty Consensus Group and RUC standards

Please describe the clinical activities of your staff:
Intra-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I
1				22206		22207		22208	
2	**April 2007 AMA/Specialty Society RVS Update Commitee**			Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic		Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); lumbar		Osteotomy of spine, posterior or posterolateral approach, three colum one vertebral segment pedicle/vertebral bo subtraction); each add vertebral segment	
3	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90	N/A	90	N/A	ZZZ
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	207	N/A	207	N/A	0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	135	N/A	135	N/A	0
9	PRE-SERVICE								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		0
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		0
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		0
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		0
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		0
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	SERVICE PERIOD								
39	Discharge day management 99238 –12 minutes 99239 –15 minutes	L037D	RN/LPN/MTA		12		12		0
41	**End: Patient leaves office/FACILITY**								
42	POST-SERVICE Period								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescnptions								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27		1		1		
49	99213 36 minutes	L037D	36		3		3		
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
53									
54	*Total Office Visit Time*			0	135	0	135	0	0
55	Other Activity (please specify)								
56	**End: with last office visit before end of global period**								
57	MEDICAL SUPPLIES	CMS Code	Unit						
58	pack, minimum multi-specialty visit	SA048	pack		4		4		0
59	pack, post-op incision care (suture & staple)	SA053	pack		1		1		0
60									
61									
62	Equipment	CMS Code	Utilization Percentage						
63	table, power	EF031	100%		135		135		0
64	light, exam	EQ168	100%		135		135		0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Internal or External Fixation-Shoulder/Elbow

As part of the 2005 Five Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2007 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty that these codes needed to be clarified and removed reference to external fixation from 64 CPT codes. These 64 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. The Hip/Knee codes will be discussed at the April 2007 RUC Meeting.

Between 225 and 450 orthopaedic providers participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, shoulder and elbow surgery and orthopaedic trauma surgery. After the results from all of these groups were tablulated, a concensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Arthroscopy Association of North America and the Orthopaedic Trauama Association met to discuss the survey data for the revised orthopaedic codes. During this review, the specialties determined that they would recommend the 25th percentile for codes in situations where all of the fracture codes, when they were arrayed in order of complexity, it was rational to recommend the 25th percentile RVU value as a means to maintain rank order. Furthermore, the specialty societies reviewed the resulting IWPUTs associated with the revised codes and determined that these IWPUT values validated the recommended work RVUs.

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The RUC reviewed the compelling evidence for these procedures. The specialty societies claimed that because the CPT descriptors originally contained the phrase "with or without internal or external fixation," it is difficult to imagine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs.

Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. There are also new internal fixation devices which require more work. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. Also, for several of the identified procedures, the provider of the services have changed and were not a part of the original Harvard studies such as the American Shoulder and Elbow Surgeons. The specialty societies conducted a full RUC survey of all codes, and for almost all of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending reductions in work RVUs for three codes of the codes in this family, 23616 and 24575.

The RUC thoroughly reviewed these codes, and as part of this review, the specialties explained that they felt strongly that a 99214 office visit was appropriate for two of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99213 office visit. The RUC reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type).* It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲23515	F3	Open treatment of clavicular fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	11.00
▲23585	F4	Open treatment of scapular fracture (body, glenoid or acromion) ~~with or without~~ includes internal fixation	090	16.25
▲23615	F5	Open treatment of proximal humeral (surgical or anatomical neck) fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, ~~with or without~~ includes repair of tuberosity(s), when performed;	090	14.00
▲23616	F6	Open treatment of proximal humeral (surgical or anatomical neck) fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, ~~with or without~~ includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement	090	21.00
▲23630	F7	Open treatment of greater humeral tuberosity fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	12.00
▲23670	F8	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	14.00
▲23680	F9	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	15.00
▲24545	F10	Open treatment of humeral supracondylar or transcondylar fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed; without intercondylar extension	090	15.00
▲24546	F11	Open treatment of humeral supracondylar or transcondylar fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed; with intercondylar extension	090	17.01
▲24575	F12	Open treatment of humeral epicondylar fracture, medial or lateral, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	11.00

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲24579	F13	Open treatment of humeral condylar fracture, medial or lateral, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	13.00

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AMA/Specialty Society RVS Update Committee
RUC Recommendations - Internal or External Fixation
CPT Code Order

CPT Code	*Descriptor*	*Global*	*RUC Rec Work RVU*	*RUC Rationale*
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 23515 Open treatment of clavicular fracture, includes internal fixation, when performed and compared it to its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC compared the intra-service times for these procedures and noted that 23515 had less intra-service time associated with it as compared to 29827, 90 and 120 minutes, respectively. The RUC compared the intensity complexity measures of 23515 amd 29827 and noted that the reference code required more technical skill to perform and had a more intense intra-service period as compared to 23515. Therefore, the RUC agreed that the median of the survey data, 11.00 RVUs, appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 23515 as 28299 has slightly more total service time associated with it in comparison to 23515, 299 minutes and 287 minutes respectively. The RUC recommends 11.00 RVUs for 23515.
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation	090	16.25	The RUC reviewed CPTcode 23585 Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation and compared it to its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC noted that the total service time for the surveyed code was lower than the reference code, 407 minutes and 469 minutes respectively. Furthermore, the RUC compared the intensities of these procedures and determined that because, 23585 is one of the most complex of the procedures performed for reduction and internal fixation of shoulder fractures and typically requires an extensive exposure of the scapula with significant muscle disection and identification and protection of the suprascapular nerve and artery, it was deemed a more intensive procedure than the reference code 27447. However, the RUC agreed that to keep this code in proper rank order with other codes in the family, such as 23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed (RUC recommended value of 15.00 RVUs) and 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement (RUC recommended value of 21.00 RVUs), the value associated with this procedure should be the 25th percentile of the survey, 16.25 RVUs. The RUC recommends 16.25 RVUs for 23585.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	090	14.00	The RUC reviewed CPT code 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; and compared it with its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC noted that the surveyed code has significantly less intra-service time associated with it as compared to the reference code, 90 minutes and 130 minutes, respectively. Further, the RUC noted that the reference service required more physical effort to perform and has a more complex intra-service period as compared to 23615. The RUC reviewed several other codes under review in this family, such as 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed (RUC Recommended value=14.00 RVUs) 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna (RUC recommended value=14.00). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the 25th percentile of the survey, 14.00 RVU appropriately places this service in comparison to 23670, 25575 and the key reference service 29827. The RUC recommends 14.00 RVU for 23615.
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement	090	21.00	The RUC reviewed CPT code 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement and compared it with its reference code 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (Work RVU=22.47). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. The RUC noted that 23616 has less intra-service time associated with it as compared to the reference code, 120 minutes and 165 minutes, respectively. Although 23472 has longer intra-service times than the surveyed code, with 23616 comminution is frequently present which makes correct positioning of the prosthesis and stable repair of the tuberosity fragments difficult this makes 23616 a very intensive procedure to perform. For further support the RUC reviewed MPC code 50546 Laparoscopy, surgical; nephrectomy, including partial ureterectomy (Work RVU=21.69). The RUC noted that 50546 had a longer intra-service time in comparison to 23616, 205 minutes and 120 minutes, respectively. Therefore, the RUC agreed that the median value of 21.00 RVUs is appropriate and correctly places this code in comparison to the reference code, 23472 and 50546. The RUC noted that the proposed value for this procedure, 21.00 RVUs, is less than the existing value, 21.68 RVUs. The RUC recommends 21.00 RVUs for 23616.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	090	12.00	The RUC reviewed CPT code 23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed and compared it to its reference code 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) (Work RVU=14.75). The RUC noted that the intra-service time of the surveyed code was far less than the intra-service time of the reference code, 70 minutes and 120 minutes. The RUC also noted that although 23630 is a shoulder fracture that commonly occurs in tandem with poor bone quality, making fixation of the fragment difficult and tenuous, the reference code is a more intensive procedure to perform. This comparison of intensity is demonstrated in the intensity measure of the intra-service time associated with the surveyed code, as it is less than the intensity associated with the reference code. Therefore, the RUC recommends the 25th percentile of the survey for this procedure, 12.00 RVUs. For further support, the RUC compared 23630 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 23630 has less intra-service time as compared to 60220, 70 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 23420. The RUC recommends 12.00 RVU for 23630.
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	090	14.00	The RUC reviewed CPT code 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed and compared it with its reference code 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) (Work RVU=14.75). The RUC noted that the surveyed code has significantly less intra-service time associated with it as compared to the reference code, 90 minutes and 120 minutes, respectively. However, all of the intensity and complexity measures demonstrated that the surveyed code was significanly more difficult to perform than the reference code. The RUC reviewed several other codes under review in this family, such as 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (RUC recommended value of 14.00 RVUs) and 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna (RUC recommended value of 14.00 RVUs). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the 25th percentile of the survey, 14.00 RVU appropriately places this service in comparison to 23615, 25575 and the key reference service 23420. The RUC recommends 14.00 RVU for 23670.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	090	15.00	The RUC reviewed CPT code 23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed and compared it to its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC noted that 23680 and 29827 have the same pre-service time (75 minutes) and intra-service time (120 minutes). The RUC agreed that that in addition to the times for these two procedures being the same that the complexity and work associated with them is similar as well. Therefore the RUC recommends the 25th percentile of the survey 15.00 RVUs to reflect this similarity in service times and work. The RUC recommends 15.00 RVUs for 23680.
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	090	15.00	The RUC reviewed CPT code 24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC reviewed the total-service times for both codes and found them to be comparable, 361 minutes and 358 minutes. However, the RUC noted that the intensity/complexity measures for 24545 were significantly higher in comparison to 25609 as the complexity and risk for complication involved in 24545 is much greater than 25609. Therefore the RUC agreed that the median value of 15.00 RVU appropriately places this code in comparison to the reference code. The RUC recommends a work RVU of 15.00 for code 24545.
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	090	17.01	The RUC reviewed CPT code 24546 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension and compared it with its reference code 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (Work RVU=22.47). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and a 99212 office visit being associated with this procedure. However, after comparing 24546 with 23472, the RUC determined that this reference code was not a suitable comparison. The RUC agreed that the better reference code would be 24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension (RUC recommended RVU=15.00 RVUs). The RUC compared the total service times for both procedures and determined at 24546 had a longer intra service time in comparison to 24545, 150 minutes and 120 minutes. The RUC also agreed that the intensity/complexity of performing 24546 is significantly higher that performing 24545 as 24545 is an extra-articular fracture and 24546 is an intra-articular fracture requiring extensive exposure of the joint. Therefore, to calculate the recommended RVUs for this procedure, the RUC started with the 25th percentile of the survey data, 16.34 RVUs and added a work RVU increment of 2.01, the difference in intra-service times between 24546 and 24545 (30 minutes) multiplied by the IWPUT of 24545 (0.067). This calculation results in a value of 17.01 RVUs. The RUC recommends 17.01 RVUs for 24546.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 305 minutes and 308 minutes. Therefore the RUC agreed that the median value of 11.00 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 24575 as 28299 has more intra- service time associated with it in comparison to 24575, 90 minutes and 60 minutes, respectively. The RUC noted that the proposed value for this procedure, 11.00 RVUs, is slightly less than the existing value, 11.02 RVUs. The RUC recommends 11.00 RVUs for 24575.
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	090	13.00	The RUC reviewed CPT code 24579 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed and compared it to 25609 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed (Work RVU=14.12). The RUC noted that the intra-service time for the surveyed code is significantly less than the reference code, 90 minutes and 120 minutes. Furthermore, the RUC noted that the reference code requires more mental effort and judgement and technical skill to perform in comparison to 24579. Because of a lower intra-service time and lower intensity and complexity measures of the surveyed code in comparison to the reference code, the RUC recommends the survey median work RVU, 13.00 RVUs for 24579 as it appropriately places this code in comparison to the reference code. For further support the RUC compared 24579 to 24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed (RUC recommended value=11.00 RVU). The RUC noted that these procedures are similar except 24579 has the addition of an intraarticular extension involving the entire condylar structure. The same neurovascular structures are at risk in 24579 and 24575 except 24579 has the added complexity of obtaining and holding the articular surface reduced anatomically to maintain joint congruity. Because of these comparisons to a reference code and another code within the family, the RUC recommends 13.00 RVUs for 24579.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	090	10.00	The RUC reviewed CPT code 24635 Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the total service time for 24635 is higher than the total service time for 25607, 291 minutes and 275 minutes, respectively. Furthermore, the work for 24635 is greater than 25607 because the dislocated radial head must be treated in addition to the ulna fracture and post-operatively there is a danger of neurovascular injury and compartment syndrome. Close monitoring is required. This is demonstrated in the intensity/complexity measures which indicate that the surveyed code requies greater mental effort and judgement, greater technical skill and greater physical effort to perform in comparison to the reference code. Furthermore, the RUC noted that this service requires a hospital stay as there is significant monitoring of circulation, sensation and motor function of the involved extremity. Therefore, the RUC agreed that the 25th percentile of the survey data, 10.00 work RVUs accurately places this code in comparison to the reference code. The RUC noted that the proposed value for this procedure, 10.00 RVUs, is less than the existing value, 13.56 RVUs. The RUC recommends 10.00 work RVUs for 24635.
24685	Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed	090	9.50	The RUC reviewed CPT code 24685 Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that while both services have an intra-service time of 60 minutes, the surveyed procedure is more complex than the reference code as 24685 is intraarticular and 25607 is extraarticular. This complexity of the intra-service is also noted in the intra-service intensity complexity measure which shows that the surveyed code's intra-service period is more intense than the intra-service time associated with the reference code. Furthermore, the intensity/complexity measures indicate that the surveyed code requires greater mental effort and judgment, greater technical skill and greater physical effort to perform in comparison to the reference code. Therefore, the RUC agreed that the 25th percentile of the survey data, 9.50 work RVUs, accurately places this code in comparsion to the reference code. The RUC recommends 9.50 work RVUs for 24685.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	090	10.00	The RUC reviewed CPT code 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, physical effort, mental effort and judgment to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 10.00 work RVU appropriately places 25515 in comparison to the reference code. The RUC recommends 10.00 work RVUs for 25515.
25525	Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed	090	12.00	The RUC reviewed CPT code 25525 Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. With this change, the RUC noted that the total service times for both of these codes are comparable, 303 minutes and 305 minutes. However, the RUC noted that the surveyed code required greater mental effort and judgment and physicial effort to perform in comparison to the reference code. Therefore, due to comparable total service times but greater intensity/complexity measures, the RUC recommends the survey median, 12.00 RVU for this procedure. For further support, the RUC compared 25525 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 25525 has less intra-service time as compared to 60220, 70 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 25608. The RUC noted that the proposed value for this procedure, 12.00 RVUs, is less than the existing value, 12.69 RVUs. The RUC recommends 12.00 RVU for 22525.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25526	Open treatment of radial shaft fracture, with internal fixation, when performed, and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	090	15.00	The RUC reviewed CPT code 25526 Open treatment of radial shaft fracture, with internal fixation, when performed, and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments. The RUC agreed that the specialty society recommended 99214 office visit should be removed and two 99212 office visit should be added as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in two 99213 office visits and three 99212 office visits being associated with this procedure. With these changes, the RUC noted that the surveyed code has more total service time associated with it in comparison to the reference code, 398 minutes and 358 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgement and more physical effort to perform and has a more complex intra-service period as compared to 25609. The difficulty of this procedure can be explained as this is the most complex of the hand procedures reviewed because this procedure consists of two separate procedures, an open reduction internal fixation of the radius which places the radial nerve in danger as well as the radial artery and a separate arthrotomy of the ulnocarpal joint and repair of the triangular fibrocartilage complex. Because of the increased total service time as well as the higher intensity/complexity measures associated with 25526 in comparison to its reference code, the RUC recommends the survey median of 15.00 work RVU for 25526. The RUC recommends 15.00 RVUs for 25526.
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	090	9.00	The RUC reviewed CPT code 25545 Open treatment of ulnar shaft fracture, includes internal fixation, when performed in compairison to 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the surveyed code and the reference code had the same intra-service time, 60 minutes. The RUC noted that 25545 requires a 99231 hospital visit as there is a danger of neurovascular injury and compartment syndrome and close monitoring is needed. The RUC also noted that the reference code requires greater endurance of psychological stress to perform as compared to the surveyed code. The RUC compared this procedure to 26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed (RUC recommended value of 9.00 RVUs) and MPC code 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less (Work RVU=9.07 and noted that because all of these procedures had similar work and the same intra-service time, 60 minutes, that they should all be valued the similarly. Therefore, because of all of these comparisons, the RUC recommends the median survey RVU, 9.00 work RVUs. The RUC noted that the proposed value for this procedure, 9.00 RVUs, is less than the existing value, 9.09 RVUs. The RUC recommends 9.00 Work RVUs for 25545.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	090	10.00	The RUC reviewed CPT code 25574 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, mental effort and judgement to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 10.00 work RVU appropriately places 25574 in comparison to the reference code. The RUC recommends 10.00 work RVUs for 25574.
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	090	14.00	The RUC reviewed CPT code 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna and compared it with its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC agreed that the specialty society recommended 99214 office visit should be removed and two 99212 office visit should be added as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in two 99213 office visits and three 99212 office visits being associated with this procedure. With these changes, the RUC noted that the surveyed code has less total service time associated with it in comparison to the reference code, 342 minutes and 358 minutes, respectively. Further, the RUC noted that the reference service required more technical skill, physical effort and more psychological stress to perform and has a more complex intra-service period as compared to 25609. The RUC reviewed several other codes under review in this family, such as 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed (RUC Recommended wRVU=14.00 RVUs) 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (RUC recommended wRVU=14.00). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the median of the survey, 14.00 RVUs appropriately places this service in comparison to 23670, 23615 and the key reference service 25609. The RUC recommends 14.00 RVUs for 25575.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 25628 Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed and compared it with its reference code 25394 Osteoplasty, carpal bone, shortening (work RVU=10.71). The RUC noted that the total service time for the surveyed code is more than the total service time for the reference code (277 minutes and 250 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the surveyed code required more technical skill, physical and mental effort and judgement to perform than the reference code. With the higher amount of total service time and higher intensity/complexity measures as compared to 25394, the RUC agreed that the 25th percentile of survey, 11.00 work RVU appropriately places 25628 in comparison to the reference code. The RUC recommends 11.00 work RVUs for 25628.
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	090	8.00	The RUC reviewed CPT code 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (work RVU=9.35). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more mental effort and judgement and more psychological stress. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25607, the RUC agreed that the 25th percentile of survey, 8.00 work RVU appropriately places 26615 in comparison to the reference code. The RUC recommends 8.00 work RVUs for 26615.
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with external fixation	090	6.00	The RUC reviewed CPT code 26650 Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with external fixation and compared it to its reference code 25651 Percutaneous skeletal fixation of ulnar styloid fracture (work RVU=5.68). The RUC compared the total service times for these procedures and noted that the surveyed code (197 minutes of total service time) had more total service time associated with it than the 25651 (190 minutes of total service time). The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25651 has one 99213 and three 99212 associated with it, which suggests the surveyed code involves more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/complexity measures which show that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. Therefore, because of the greater total service time and the more intense post-operative visits, the RUC agreed that the median RVU of the survey data appropriately places 26650 in comparison to 25651. The RUC recommends 6.00 RVUs for 26650.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed	090	9.00	The RUC reviewed CPT code 26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed in comparison to 25652 Open treatment of ulnar styloid fracture (Work RVU=7.92). The RUC noted that the surveyed code had a greater total service time associated with it in comparison to the reference code, 237 minutes and 225 minutes, respectively. The RUC also noted that the surveyed procedure requires greater physicial effort and an endurance of greater psychological stress to perform as compared to the reference code. Furthermore, the surveyed code is a more complex procedure to perform than the reference code given the increased intensity of dealing with an intraarticular fracture as demonstrated in the intensity/complexity time measures which shows that surveyed code is a much more intense procedure to perform than the reference code. The RUC agreed that because of the larger total service time and the greater amount of intensity and complexity associated with the surveyed code as compared to the reference code, the RUC recommends the median survey RVU, 9.00 work RVUs. In addition, the RUC agreed this value is appropriate because it has similar work and the same intra-service time as MPC code 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less (Work RVU=9.07). The RUC recommends 9.00 Work RVUs for 26665.
26685	Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint	090	8.00	The RUC reviewed CPT code 26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service times for both procedures are 60 minutes. The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25652 has one 99213 and three 99212 associated with it which suggests the surveyed code has a more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/ complexity measure which shows that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. With the same amount of intra-service time and slightly different office visits as compared to 25652, the RUC agreed that the median of the survey, 8.00 work RVUs appropriately places 26685 in comparison to the reference code, 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone and 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed which all have the same complexity and proposed work RVU. The RUC recommends 8.00 work RVUs for 26685.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	090	7.95	The RUC reviewed CPT code 26715 Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed and compared it to its reference code, 25671 Percutaneous skeletal fixation of distal radioulnar dislocation (Work RVU=6.32). The RUC compared the total service times for these procedures and noted that the surveyed code (220 minutes of total service time) had more total service time associated with it than the 25671 (210 minutes of total service time). The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25651 has one 99213 and three 99212 associated with it which suggests the surveyed code involves more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/ complexity measure which shows that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. Therefore, because of the greater total service time and the more intense post-operative visits, the RUC agreed that the median RVU of the survey data 7.95 work RVUs, appropriately places 26715 in comparison to 25671. Furthermore, the RUC agreed that this value correctly places this procedure in terms of complexity in comparison to other orthopaedic codes such that it is more complex than 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single (RUC recommended work RVU =7.45 work RVU) and has similar complexity to 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC recommended work RVU=8.00). The RUC recommends 7.95 RVUs for 26715.
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	090	8.40	The RUC reviewed CPT code 26735 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more physical effort and more psychological stress to perform than the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 8.40 work RVUs appropriately places 26735 in comparison to the reference code. Furthermore, the RUC compared the surveyed code with MPC code 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (Work RVU=8.44) and agreed that 8.40 RVU was an approriate value for the surveyed code because the surveyed code had similar total-service time as compared to this procedure, 237 minutes and 223 minutes, respectively. The RUC recommends 8.40 work RVUs for 26735.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	090	11.10	The RUC reviewed CPT code 26746 Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 303 minutes and 305 minutes. However, the RUC noted that the intensity/complexity measures for 26746 were significantly higher in comparison to 25608 as the complexity and risk for complication involved in 26746 is much greater than 25608. Therefore the RUC agreed that the median value of 11.10 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.10 work RVUs was appropriate for 26746 as 28299 has more intra- service time associated with it in comparison to 27832, 90 minutes and 83 minutes respectively. The RUC recommends 11.10 RVUs for 26746.
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	090	6.60	The RUC reviewed CPT code 26765 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical effort, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25652, the RUC agreed that the 25th percentile of survey, 6.60 work RVU appropriately places 26765 in comparison to the reference code. The RUC recommends 6.60 work RVUs for 26765.
26785	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single	090	7.45	The RUC reviewed CPT code 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical effort, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25652, the RUC agreed that the 25th percentile of survey, 7.45 work RVU appropriately places 26785 in comparison to the reference code. The RUC recommends 7.45 work RVUs for 26785.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	090	8.50	The RUC reviewed CPT code 27766 Open treatment of medial malleolus fracture, includes internal fixation, when performed and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (work RVU=9.35). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC noted that this procedure requires a 99231 hospital stay because of the risk of post-operative complications. The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, physical effort and more psychological stress to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25607, the RUC agreed that the 25th percentile of survey, 8.50 work RVU appropriately places 27766 in comparison to the reference code. The RUC noted that the proposed value for this procedure, 8.50 RVUs, is less than the existing value, 8.73 RVUs. The RUC recommends 8.50 work RVUs for 27766.
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	10.45	The RUC reviewed CPT code 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the total service time of 27784 is higher than the total service time of the reference code, 281 minutes and 275 minutes, respectively. The RUC reviewed the intensity complexity measures associated with 27784 and 25607. The RUC noted that 27784 requires more technical skill, physical effort and psychological stress to perform than the reference code. With the higher amount of total service time of the surveyed code in comparison to the reference code and the higher intensity/complexity measures of the surveyed code in comparison to the reference code, the RUC agreed that the median of the survey, 10.45 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.45 RVU for 27784 was appropriate as the intra-service time for 27784 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.45 RVUs for 27784.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	090	10.50	The RUC reviewed CPT code 27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the intra-service time of 27792 is significantly less than the intra-service time of the reference code, 60 minutes and 90 minutes, respectively. The RUC also noted that the care for this type of fracture is slightly more complex than 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed (RUC Recommended Value=10.45). With the lower amount of intra-service time of the surveyed code in comparison to the reference code and maintaining the proper rank order between the surveyed code and 27784, the RUC agreed that the median of the survey, 10.50 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.50 RVU for 27792 was appropriate as the intra-service time for 27792 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.50 RVUs for 27792.
27814	Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed	090	11.50	The RUC reviewed CPT code 27814 Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC compared the intra-service times for these procedures and noted that 27814 had less intra-service time associated with it as compared to 25609, 90 and 120 minutes, respectively. The RUC compared the intensity complexity measures of 27814 amd 25609 and noted that the reference code required more physical effort, mental effort and judgement to perform as compared to 23515. Therefore, the RUC agreed that the 25th percentile of the survey data, 11.50 RVUs, appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.50 work RVUs was appropriate for 27814 as 28299 has the less total service time than the 27814, 299 minutes and 346 minutes respectively. The RUC recommends 11.50 RVUs for 27814.
27822	Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	090	12.12	The RUC reviewed CPT code 27822 Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed since the RUC last reviewed it in 2000. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 27822 be maintained at its current value, 12.12.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27823	Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	090	14.26	The RUC reviewed CPT code 27823 Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed since the RUC last reviewed it in 2000. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 27823 be maintained at its current value, 14.26 RVUs.
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	12.00	The RUC reviewed CPT code 27826 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. The RUC noted that the intra-service time of the surveyed code was far less than the intra-service time of the reference code, 60 minutes and 120 minutes. The RUC compared the intensity/complexity mesaures for these procedures and noted that they were comparable. The RUC after revieweing these times and complexity measures associated with the key reference code and the surveyed code agreed that this surveyed code has the same amount of complexity and work as 25525 Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed, 23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed and 25585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed and therefore recommends that this procedure be valued the same as these other reference codes (all three codes RUC recommended RVU=12.00). The RUC recommends 12.00 RVUs for 27826. For further support, the RUC compared 27826 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 27826 has less intra-service time as compared to 60220, 60 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the key reference code, 25609. The RUC recommends 12.00 RVU for 27826.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	090	16.00	The RUC reviewed CPT code 27827 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 27827 with 27447, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed and the RUC recommended that its value be maintained, could now be used as an alternative reference code. The RUC compared the total service times for both procedures and determined at 28445 had a longer total service time in comparison to the surveyed code 485 minutes and 458 minutes. In addition, the RUC agreed that the intensity and complexity of performing 28445 would be greater than performing 27827. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 16.00 RVUs for 27827.
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	090	20.00	The RUC reviewed CPT code 27828 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 27828 with 27447, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed, could now be used as an alternative reference code. The RUC compared the intra-service times for both procedures and determined at 27828 had a longer intra-service time in comparison to the reference code, 150 minutes and 125 minutes. In addition, the RUC agreed that the intensity and complexity of performing 27828 would be greater than performing 28445. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 20.00 RVUs for 27828.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	9.50	The RUC reviewed CPT code 27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation. The RUC noted that although the reference code has more intra-service time compared with it than the reference code, 60 minutes and 45 minutes, respectively, that the surveyed code has more pre-service time associated with it as more time is required in 27829 to evaluate the fracture. The intensity and risk for complication involved in treating the distal tibia fracture is much greater than the intensity and risk for complication involved with 25607. This is demonstrated in the intensity/comlexity measures which demonstrates that 27829 requires more mental effort and judgement, more technical skill and physical effort and is an overall more intense code to perform than 25607. In addition, the surveyed code has more post-operative work in comparison to 25607, because 27829 requires hospitialization to avoid skin issues, swelling and to assess neurocirculatory status. Because of the greater amount of intensity as well as the hospitalization associated with this service, the RUC agreed the 25th percentile of the survey, 9.50 RVUs accurately places this procedure in comparison to the reference code. The RUC recommends 9.50 RVUs for 27829.
27832	Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	090	11.00	The RUC reviewed CPT code 27832 Open treatment of proximal tiblofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 301 minutes and 305 minutes. However, the RUC noted that the intensity/complexity measures for 27832 were significantly higher in comparison to 25608 as the complexity and risk for complication involved in open treatment of the trimalleolar ankle fracture is much greater than 25608. Therefore the RUC agreed that the median value of 11.00 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 27832 as 28299 has more intra- service time associated with it in comparison to 27832, 90 minutes and 75 minutes respectively. The RUC recommends 11.00 RVUs for 27832.
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	090	17.54	The RUC reviewed CPT code 28415 Open treatment of calcaneal fracture, includes internal fixation and recommended that a 99214 office visit should be removed and substituted with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. The RUC agreed that the new survey time data for this procedure further validated the existing work RVUs for this procedure and recommend maintaing the value for this code. The RUC recommends that the new surveyed times be applied to this code and maintaining the current work of 17.54 RVUs for 28415.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	090	19.00	The RUC reviewed CPT code 28420 Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft) and compared it with its reference code 27487 Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component (Work RVU=26.91). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 28420 with 27847, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed, could now be used as an alternative reference code as the RUC recommended that the value for this service be maintained at its existing value. The RUC compared the intra-service times for both procedures and determined at 28420 had a longer intra-service time in comparison to the reference code, 150 minutes and 125 minutes. In addition, the RUC agreed that the intensity and complexity of performing 28420 would be greater than performing 28445. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 19.00 RVUs for 28420.
28445	Open treatment of talus fracture, includes internal fixation, when performed	090	17.07	The RUC reviewed CPT code 28445 Open treatment of talus fracture, includes internal fixation, when performed and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 28445 be maintained at its current value, 17.07 RVUs.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	090	9.50	The RUC reviewed CPT code 28465 Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). In addition, the number of post-operative visits is not the same as the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with three 99213 office visits and two 99212, which suggests the surveyed code involves less complex post operative care as compared to the reference code. However, the RUC also compared this procedure to 24685 Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed (RUC recommended work RVU=9.50) and 27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed (RUC Recommended work RVU=9.50). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as compared to 25608, the RUC agreed that 9.50 work RVU appropriately places 28465 in comparison to 25608, 24685 and 27829. The RUC recommends 9.50 work RVUs for 28465.
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	090	8.00	The RUC reviewed CPT code 28485 Open treatment of metatarsal fracture, includes internal fixation, when performed, each and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with three 99213 office visits and one 99212 office visit, which suggests the surveyed code involves less complex post operative care as compared to the reference code. The RUC noted that the reference code required more mental effort and judgement, more technical kill and physical effort and greater psychological stress to perform than the surveyed code. Also, the RUC also compared this procedure to 26615 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint (RUC recommended work RVU=8.00), 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC Recommended work RVU=8.00) and 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone (RUC recommended work RVU=8.00). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as well as the lower intensity and complexity measures as compared to 28299, the RUC agreed that 8.00 work RVU appropriately places 28485 in comparison to 28299, 26685, 28645 and 26615. The RUC recommends 8.00 work RVUs for 28485.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28505	Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed	090	8.00	The RUC reviewed CPT code 28505 Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed and compared it with its reference code 28750 Arthrodesis, great toe; metatarsophalangeal joint (Work RVU=8.37). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 75 minutes, respectively). Additional pre-service time is associated with the surveyed code because this procedure involves the evaluation of a fracture which requires additional positioning and prep time as compared to the reference code. The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code involves less complex post operative care as compared to the reference code. However, the RUC also compared this procedure to 26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint (RUC recommended work RVU=8.00), 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC Recommended work RVU=8.00) and 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone (RUC recommended work RVU=8.00). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as compared to 28750, the RUC agreed that 8.00 work RVU appropriately places 28525 in comparison to 28750, 26685, 28645 and 26615. The RUC recommends 8.00 work RVUs for 28505.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	090	6.00	The RUC reviewed CPT code 28525 Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each and compared it with its reference code 28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint (Work RVU=8.11). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (30 minutes and 45 minutes, respectively). Additional pre-service time is associated with the surveyed code because this procedure involves a fracture with fixation, which requires more positioning and prep time as compared to the reference code. The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code involves a less complex post operative care as compared to the reference code. The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical skill, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 28289, the RUC agreed that the 25th percentile of survey, 6.00 work RVU appropriately places 28525 in comparison to the reference code. Furthermore, the RUC compared the surveyed code with MPC code 11646 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm (Work RVU=6.21) and agreed that 6.00 RVU was an approriate value for the surveyed code because the surveyed code had significantly less intra-service time than this procedure, 30 minutes and 60 minutes, respectively. The RUC recommends 6.00 work RVUs for 28525.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	10.43	The RUC reviewed CPT code 28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed and compared it with its reference code 28261 Capsulotomy, midfoot; with tendon lengthening (Work RVU=12.91). The RUC noted that the intra-service time of 28555 is significantly less than the intra-service time of the reference code, 60 minutes and 103 minutes, respectively. The RUC reviewed the post-operative visits for this service and determined that to make this service comparable to other codes within the family, 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed (RUC recommended work RVU=10.45) and 27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed (RUC recommended work RVU=10.50), that the specialty societies' recommendation of including a 99214 office visit should be removed from the post-operative visits associated with this code as only two 99213 and two 99212 office visits is more typical of the post-operative care for the typical patient. With the lower amount of intra-service time of the surveyed code in comparison to the reference code and the same post-operative visits as 27784 and 27792, the RUC agreed that the 25th percentile of the survey, 10.43 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.43 RVU for 28555 was appropriate as the intra-service time for 28555 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.43 RVUs for 28555.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	090	12.00	The RUC reviewed CPT code 28585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (work RVU=11.39). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and two 99212 office visits being associated with this procedure. With this change, the RUC noted that the total service times for 28585 is greater than the reference code, 324 minutes and 299 minutes. Additionally, the RUC noted that the surveyed code required greater mental effort and judgement and physicial effort to perform in comparison to the reference code. This intensity of this service is much in part due to the joint that is operated on as it is more proximal and involves larger bones as compared to the tarsometatarsal dislocation procedure. Two bones are involved in this type of dislocation and the risk for post-operative complications is high. Therefore, due more total service time and greater intensity/complexity measures as compared to the reference code, the RUC recommends the 25th percentile of the survey, 12.00 RVUs for this procedure. For further support, the RUC compared 28585 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 28585 has less intra-service time as compared to 60220, 75 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 28299. The RUC recommends 12.00 RVUs for 28585.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	11.50	The RUC reviewed CPT code 28615 Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed and compared it to its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). After hearing the specialty societies' presentation for this code agreed that an additional 10 minutes of pre-service evaluation time and an additional 5 minutes of pre-service scrub, dress and wait time was needed to account for the fact that this procedure involves two bones which increases the complexity and risk associated with this procedure and consequently increases the evaluation and scrub, dress and wait time. Furthermore, the RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and two 99212 office visits being associated with this procedure. With these changes, the RUC noted that 28615 had more total service time than the reference code, 323 minutes and and 299 minutes respectively. Further, the surveyed code requires greater technical skill, physicial effort and psychgological stress to perform in comparison to the reference code. Therefore the RUC agreed that the approriate value for this procedure is the 25th percentile of the survey data, 11.50 RVUs as this value appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to 28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed (RUC recommended RVU=10.43). As treating the type of dislocation involved in 28615 is more difficult than treating a dislocation involving a single bone as in 28555, the proposed value of 11.50 RVU appropriately place this procedure in comparison to 28555. The RUC recommends 11.50 RVUs for 28615
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	090	8.00	The RUC reviewed CPT code 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed and compared it with its reference code 28292 Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure (work RVU=8.72). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code has a less complex post operative care as compared to the reference code. The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more technical skill and more psychological stress. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 28292, the RUC agreed that the 25th percentile of survey, 8.00 work RVU appropriately places 28645 in comparison to the reference code. The RUC recommends 8.00 work RVUs for 28645.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	090	6.00	The RUC reviewed CPT code 28675 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed and compared it with 28288 Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head (work RVU=5.81). The RUC compared the service times of both procedures and noted that although the intra-service times are the same (30 minutes), 28675 had considerable more pre-service time associated with it than 28288 (55 minutes and 20 minutes, respectively). The surveyed code has more pre-service time associated with it because in involves a dislocation requiring fixation, which requires additional positioning and prep time. The reference code does not require fixation. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater mental effort and judgement and more overall intensity to perform than the reference code. Therefore, the RUC agreed that because of the greater amount of time and the greater mental effort and judgement associated with the surveyed code in comparison to the reference code, the RUC recommends survey median RVU, 6.00 RVUs for 28675. The RUC recommends 6.00 RVUs for 28675.

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:23515 Tracking Number F3 Specialty Society Recommended RVU: **11.00**
Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Open treatment of clavicular fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old male falls and lands on his right shoulder and suffers a displaced clavicle fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the clavicular shaft. Hemostasis is meticulously controlled with electrocautery. The periosteum, with the trapezial and deltoid fascia, is elevated and the fracture site and configuration is confirmed. Options are reviewed and the fracture reduction is performed. Because of the proximity of the neurovascular structures underneath the clavicle, extreme caution is exercised to protect these structures. Often an interfragmentary screw is required to maintain a reduction while plates or screws are placed to stabilize the fracture. Multiple plating and screw configurations are possible. Rarely four screws are adequate and more often six, eight or ten screws are required to plate and screw the fracture. Once the fracture is reduced and secured with plate and screws the wound is copiously irrigated with antibiotic saline. The periosteum is repaired and the wound is closed in layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntryre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	23515				
Sample Size:	250	**Resp N:** 10	**Response:** 4.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**5.00**	9.00	15.00
Survey RVW:	9.50	11.00	**15.00**	15.00	15.40
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	40.00	75.00	**90.00**	90.00	150.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**			

Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 23515	
	Specialty Recommended
Physician Work RVU:	11.00
Pre-Service Evaluation Time:	40.0
Pre-Service Positioning Time:	15.0
Pre-Service Scrub, Dress, Wait Time:	15.0
Intra-Service Time:	90.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29827	090	15.44	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; with rotator cuff repair

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	12.29	RUC Time

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

umber of respondents who choose Key Reference Code: 2 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)

	CPT Code: 23515	Key Reference CPT Code: 29827	Source of Time RUC Time
Median Pre-Service Time	70.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	80.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**287.00**	**334.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

"he number of possible diagnosis and/or the number of anagement options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.00
Urgency of medical decision making	4.50	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.50
Physical effort required	4.50	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.00
Outcome depends on the skill and judgment of physician	3.50	3.00
Estimated risk of malpractice suit with poor outcome	2.00	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.00
Intra-Service intensity/complexity	3.00	3.50
Post-Service intensity/complexity	3.00	1.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23515, we recommend 11.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23515 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

›y reference code 29827 requires more total work than 23515, although the fracture reduction and fixation can be ›omplex because of the common occurrence of significant comminution, the procedure is straightforward and not as intense/complex as 29827. Additionally, the neurovascular structures, most notably the subclavian vein, run directly under the clavicle and are at risk during the procedure. The consensus panel believes that 25th percentile work RVU correctly reflects the relationship to 29827.

Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. The first office visit would include removal of the sling and dressing, redressing, discussion of restrictions and operative findings, reapplication of sling and instruction on ROM. X-rays would be reviewed. The second visit would be for sling and dressing removal, suture removal and X-rays would be taken and reviewed. The sling would be reapplied and restrictions discussed. The third visit would include assessment of wound healing and ROM. X-rays would be taken and reviewed assess bone alignment and healing. Motion exercises would be prescribed. The final visit would assess ROM and X-r would be taken and reviewed to assess bone healing.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 50% No 50%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 20% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23515

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		83.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from ·bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:23585 Tracking Number F4 Specialty Society Recommended RVU: **16.25**
Global Period: 090 RUC Recommended RVU: **16.25**

CPT Descriptor: Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male falls and suffers a displaced scapular fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. The patient is placed in the lateral decubitus or prone position. The arm and shoulder are prepped and draped.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the scapula. Because of the scapular anatomy, the approach to the fracture maybe extremely variable and multiple. Hemostasis is meticulously controlled with electrocautery. The periosteum, with the trapezial, deltoid, supra or infraspinatus fascia, is elevated and the fracture site and configuration is confirmed. Options are reviewed and the fracture reduction is performed. Because of the proximity of the neurovascular structures and the chest wall, extreme caution is exercised to protect these structures. Often an interfragmentary screw is required to maintain a reduction while plates or screws are placed to stabilize the fracture. Multiple plating and screw configurations are possible and frequently necessary. Because of the anatomy, often two plates are required. Once the fracture is reduced and secured with plate and screws the wound is copiously irrigated with antibiotic saline. The periosteum is repaired and the wound is closed in layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	23585				
Sample Size:	250	**Resp N:** 10	**Response:** 4.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**1.00**	3.00	6.00
Survey RVW:	12.00	16.25	**24.25**	25.00	30.10
Pre-Service Evaluation Time:			**75.0**		
Pre-Service Positioning Time:			**23.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	90.00	120.00	**120.00**	173.00	240.00
Immediate Post Service-Time:	**33.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			

CPT Code: 23585

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**100.0**	99231x **1.0** 99232x **2.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t. following table, and tab through to the key reference service box.

CPT Code: 23585		
		Specialty Recommended
Physician Work RVU:		16.25
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		23.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	33.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 2.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27447	090	23.04	RUC Time

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58150	090	33,064	17.21	RUC Time

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)

	CPT Code: 23585	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	98.00	75.00	
Median Intra-Service Time	120.00	124.00	
Median Immediate Post-service Time	33.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	78.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**407.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

he number of possible diagnosis and/or the number of management options that must be considered	4.25	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.00
Urgency of medical decision making	4.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	3.00
Physical effort required	3.50	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.00
Outcome depends on the skill and judgment of physician	4.50	3.33
Estimated risk of malpractice suit with poor outcome	3.25	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.67
Intra-Service intensity/complexity	4.00	3.67
Post-Service intensity/complexity	3.25	2.33

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23585, we recommend 16.25 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23585 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This is one of the most complex of the procedures performed for reduction and internal fixation of shoulder fractures. This typically requires an extensive exposure of the scapula, with significant muscle dissection, and identification and protection of the suprascapular nerve and artery. Fixation typically requires multiple plates and screws.
23585 requires less postoperative work than the key reference code 27447. the consensus panel felt that the 25th percentile correctly reflected the difference in time and work. This value of 16.25 also correctly places 23585 greater than 23680 and less than 23616.

Postoperative close monitoring is required for assessment of the circulation, sensation and motor function of the involved extremity, as well as evaluation and management of pain control. Hospital work involves removal of the immobilization device, as well as a dressing changes, with each wound inspection. Physical therapy would be started and a discussion with the patient and therapist regarding the protocol and limitations is necessary. Multiple post-discharge office visits a necessary for assessment of the wound, suture removal, ROM and review of x-rays. Progress with rehabilitation thera is evaluated and instructions regarding immobilization, activity, physical therapy, and restrictions would be provided.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 50% No 50%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 100% I do not agree
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23585

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		102.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A`	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:23615 Tracking Number F5 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **14.00**

CPT Descriptor: Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female falls and suffers a two part proximal humerus fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle or the patient is placed in the beach chair position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the proximal humerus in the deltopectoral interval. Hemostasis is meticulously controlled with electrocautery. The cephalic vein is retracted with either the deltoid or the pectoralis and protected throughout the case. The fracture fragments (parts) are evaluated and reduced. The reduction, including the tuberosities is often complex requiring reduction of fragments one to another and then reduction of the larger fragments. Because of the proximity of the neurovascular structures extreme caution is exercised to protect these structures. Often an interfragmentary screw or reduction K wires are required to maintain the reduction while plates or screws are placed to stabilize the fracture. Multiple plating and screw configurations are possible. Once the fracture is reduced and secured with plate and screws the wound is copiously irrigated with antibiotic saline. The periosteum is repaired and the wound is closed in layers.

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

- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association					
CPT Code:	23615					
Sample Size:	250	**Resp N:**	46	**Response:** 0.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**6.00**	10.00	25.00
Survey RVW:		9.35	14.00	**17.50**	20.00	30.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	71.00	**90.00**	120.00	120.00
Immediate Post Service-Time:	**30.00**					

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
)ischarge Day Mgmt:	38.0	99238x 1.00 99239x 0.00
Office time/visit(s):	102.0	99211x 0.0 12x 1.0 13x 2.0 14x 1.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 23615		
		Specialty Recommended
Physician Work RVU:		15.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29827	090	15.44	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; with rotator cuff repair

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

umber of respondents who choose Key Reference Code: 10 **% of respondents:** 21.7 %

TIME ESTIMATES (Median)

	CPT Code: 23615	Key Reference CPT Code: 29827	Source of Time RUC Time
Median Pre-Service Time	75.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	85.0	80.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**338.00**	**334.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of anagement options that must be considered	4.20	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.86
Urgency of medical decision making	3.60	3.57

Technical Skill/Physical Effort (Mean)

Technical skill required	4.30	4.00
Physical effort required	3.50	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.67
Outcome depends on the skill and judgment of physician	3.70	3.58
Estimated risk of malpractice suit with poor outcome	3.10	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.10	3.14
Intra-Service intensity/complexity	3.20	3.43
Post-Service intensity/complexity	3.30	2.86

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

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Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23615, we recommend 15.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23615 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

he consensus panel compared the work of 23615 to the key reference code 29827 which has greater intra-op work, but .ess post-op work because 23615 requires hospitalization. The panel believes that total work for both procedures is very similar. We are recommending a value of 15.00 which is between the 25th percentile and the median. This value is slightly less than the reference code, but correctly equal to 24545 and greater than 23670 and 27826. Post-operatively, hospital work is required to evaluate the neurovascular status, change the operative dressing, remove the Hemovac if inserted, adjust the sling and abduction pillow and review the post-operative motion and care instructions. Multiple office

visits are required to evaluate the wound and neurovascular status, remove the sutures, review the post-operative instructions including range of motion and active motion limitations, obtain an X-ray and review the findings. Any medications prescriptions are renewed and physical therapy is discussed. Maintenance of the joint reduction while attempting to restore early motion is critical during the entire post-operative/global period. The second visit is to assure proper wound healing, re-evaluate the neurovascular status, and assess ROM. The third and fourth visits are to che the wound, neurovascular status, a X-ray is obtained and reviewed, increases in the active motions and gentle resistan exercises and increase the activities of daily living/recreation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 50% No 50%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23615

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 5.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

,PT Code:23616 Tracking Number F6 Specialty Society Recommended RVU: **21.00**
Global Period: 090 RUC Recommended RVU: **21.00**

CPT Descriptor: Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female falls and suffers a comminuted four part proximal humerus fracture requiring hemiarthroplasty.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle. The patient is then very carefully placed in the beach chair position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the proximal humerus in the deltopectoral interval. Hemostasis is meticulously controlled with electrocautery. The cephalic vein is retracted with either the deltoid or the pectoralis and protected throughout the case. The clavipectoral fascia is released and the conjoined tendon is retracted. The subscapularis is identified and the lesser tuberosity is accessed. If it is attached to the humeral head, the tendon capsular attachment is incised. The fracture fragments (parts) are evaluated and reduced. The complexity of the fracture fragments and especially the articular surface are evaluated. The articular surface is removed and the prothesis is trailed and all loose fragments are removed or reduced to the fins of the prosthesis. The reduction, including the tuberosities is often complex, requiring reduction of fragments one to another, and then reduction of the larger fragments to the prosthesis. Depending on the stability of the prosthesis cementing of the prosthesis is often required. Before the cement is inserted and/or before the prosthesis is placed, drill holes are often required in the humeral shaft to stabilize the fracture as well. Because of the proximity of `e neurovascular structures extreme caution is exercised to protect these structures. Once the fracture(s) are reduced ,d secured and the prosthesis is secured the wound is copiously irrigated with antibiotic saline. The subscapularis and capsule are repaired and the wound is closed in multiple layers.

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

- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	23616				
Sample Size:	250	**Resp N:** 46	**Response:** 18.4 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**3.00**	5.00	20.00
Survey RVW:	14.00	18.00	**21.00**	23.03	35.00
Pre-Service Evaluation Time:			**50.0**		
Pre-Service Positioning Time:			**15.0**		

CPT Code: 23616

Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		50.00	90.00	**120.00**	135.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**60.0**	99231x **1.0**	99232x **1.0**	99233x **0.0**		
Discharge Day Mgmt:	**38.0**	99238x **1.00**	99239x **0.00**			
Office time/visit(s):	**102.0**	99211x **0.0**	12x **1.0**	13x **2.0**	14x **1.0**	15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0**	55x **0.0**	56x **0.0**	57x **0.0**	

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 23616		
		Specialty Recommended
Physician Work RVU:		21.00
Pre-Service Evaluation Time:		50.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23472	090	22.47	RUC Time

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
37215	090	6,992	19.58	RUC Time

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	RUC Time

CPT Descriptor 2 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 43.4 %

TIME ESTIMATES (Median)

	CPT Code: 23616	Key Reference CPT Code: 23472	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	120.00	165.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**413.00**	**458.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.53	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.16	3.57
Urgency of medical decision making	4.05	3.57

Technical Skill/Physical Effort (Mean)

Technical skill required	4.47	4.14
Physical effort required	3.42	3.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.72	3.43
Outcome depends on the skill and judgment of physician	4.28	3.64
Estimated risk of malpractice suit with poor outcome	3.28	3.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.70	3.27
Intra-Service intensity/complexity	3.50	3.27
Post-Service intensity/complexity	3.40	2.53

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23616, we recommend 21.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23616 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

ode 23472 is a good reference for this code. Both procedures typically occur in elderly patients with osteopenic bone. ith respect to 23616, comminution is frequently present which makes correct positioning of the prosthesis and stable repair of the tuberosity fragments difficult; these are both critical technical aspects directly related to functional outcome, representing additional complexity compared with 23472. The survey median work RVU correctly accounts for less intra-op time, but greater intra-op complexity. Post-op visits vary in location and level, but basically are similar in total.

Postoperative close monitoring is required for assessment of the circulation, sensation and motor function of the involved extremity, as well as evaluation and management of pain control. Hospital work involves removal of the immobilization device, as well as a dressing changes, with each wound inspection. Physical therapy would be started and a discussion with the patient and therapist regarding the protocol and limitations is necessary. Multiple post-discharge office visits are necessary for assessment of the wound, suture removal, ROM and review of x-rays. Progress with rehabilitation there is evaluated and instructions regarding immobilization, activity, physical therapy, and restrictions would be provided.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 61% No 39%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 92%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23616

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

.PT Code:23630 Tracking Number F7 Specialty Society Recommended RVU: **12.00**
Global Period: 090 RUC Recommended RVU: **12.00**

CPT Descriptor: Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female falls on her upper arm and suffers a displaced tuberosity fracture requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle or the patient is placed in the beach chair position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the proximal humerus in the deltopectoral interval. Hemostasis is meticulously controlled with electrocautery. The cephalic vein is retracted with either the deltoid or the pectoralis and protected throughout the case. The fracture fragments (parts) are evaluated and reduced. The reduction is often complex requiring reduction of fragments one to another and then reduction of the larger fragments. Because of the proximity of the neurovascular structures extreme caution is exercised to protect these structures. Often interfragmentary screws and/or reduction K wires are required to maintain the reduction while plates or screws are placed to stabilize the fracture. Multiple plating and screw configurations are possible. Once the fracture is reduced and secured with plate and screws, the wound is copiously irrigated with antibiotic saline. The periosteum, rotator cuff musculature and deltoid muscle/fascia are repaired and the wound is closed in multiple layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntryre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	23630				
Sample Size:	250	**Resp N:** 46	**Response:** 18.4 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**3.00**	5.00	20.00
Survey RVW:	9.35	12.00	**14.21**	16.00	25.00
Pre-Service Evaluation Time:			**43.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	40.00	60.00	**70.00**	90.00	150.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
ffice time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 23630	
	Specialty Recommended
Physician Work RVU:	12.00
Pre-Service Evaluation Time:	43.0
Pre-Service Positioning Time:	15.0
Pre-Service Scrub, Dress, Wait Time:	15.0
Intra-Service Time:	70.00

Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23420	090	14.75	RUC Time

CPT Descriptor Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 1 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

umber of respondents who choose Key Reference Code: 16 **% of respondents:** 34.7 %

TIME ESTIMATES (Median)

	CPT Code: 23630	Key Reference CPT Code: 23420	Source of Time RUC Time
Median Pre-Service Time	73.00	45.00	
Median Intra-Service Time	70.00	120.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	115.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**306.00**	**368.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of anagement options that must be considered	3.75	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.33
Urgency of medical decision making	3.25	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.06	4.00
Physical effort required	3.63	3.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.06	2.82
Outcome depends on the skill and judgment of physician	3.25	3.00
Estimated risk of malpractice suit with poor outcome	2.81	2.82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.93	2.92
Intra-Service intensity/complexity	3.07	3.15
Post-Service intensity/complexity	3.47	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

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- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23630, we recommend 12.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23630 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

ıis is a shoulder fracture code that commonly occurs in tandem with poor bone quality making fixation of the fragment ıifficult and tenuous. Both 23420 and 23630 require hospitalization. The consensus panel recommends the 25th percentile work RVU. This value is correctly lower than the key reference code and takes into account less intra work and less office work. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. There is a significant danger of loss of fixation because of poor bone quality and stiffness secondary to immobilization. The first office visit would include removal of the sling and dressing, redressing, discussion of restrictions

and operative findings, reapplication of sling and instruction on ROM. X-rays taken to assess fracture reduction would be reviewed. The second visit would be for sling and dressing removal, suture removal and X-rays would be taken and reviewed. The sling would be reapplied and restrictions discussed. The third visit would include assessment of wound healing and ROM. X-rays would be taken and reviewed to assess bone alignment and healing. Motion exercises would be prescribed. The final visit would assess ROM and X-rays would be taken and reviewed to assess bone healing.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 37% No 63%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 6% I do not agree 94%
B. Patients requiring this service are now:
   more complex (more work) 71% less complex (less work) 0% no change 29%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 6% no change 94%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23630

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		72.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		70.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

:PT Code:23670 Tracking Number F8 Specialty Society Recommended RVU: **14.00**
Global Period: 090 RUC Recommended RVU: **14.00**

CPT Descriptor: Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male suffers a fracture dislocation of the shoulder requiring open reduction and internal fixation of the displaced tuberosity fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle or the patient is placed in the beach chair position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the proximal humerus in the deltopectoral interval. Hemostasis is meticulously controlled with electrocautery. The cephalic vein is retracted with either the deltoid or the pectoralis and protected throughout the case. The humeral head position is noted. The capsuloligamentous structures and the rotator cuff are evaluated and released as needed to carefully reduce the humeral head. Avoidance of further injury to the articular surface is mandatory during the reduction procedure. Any loose fragments are removed from the joint space. Reduction of the tuberosities is often complex requiring reduction of fragments one to another and then reduction of the larger fragment to the humerus. Because of the proximity of the neurovascular structures extreme caution is exercised to protect these structures. Often an interfragmentary screw and/or reduction K wires are required to maintain the reduction, while plates and/or screws are positioned to stabilize the fracture. Multiple plating and screw configurations are possible. Once the fracture is reduced and secured with plate and screws the wound is copiously irrigated with antibiotic saline. The ·eriosteum, capsule and musculotendinous units are repaired and the wound is closed in multiple layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This require removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	23670				
Sample Size:	250	**Resp N:** 23	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**2.00**	3.00	6.00
Survey RVW:	9.35	14.00	**15.00**	15.50	25.00
Pre-Service Evaluation Time:			**40.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	45.00	73.00	**90.00**	113.00	150.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 23670		
		Specialty Recommended
Physician Work RVU:		14.00
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
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Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23420	090	14.75	RUC Time

CPT Descriptor Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58150	090	33,064	17.21	RUC Time

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

ımber of respondents who choose Key Reference Code: 8 **% of respondents:** 34.7 %

TIME ESTIMATES (Median)

	CPT Code: 23670	Key Reference CPT Code: 23420	Source of Time RUC Time
Median Pre-Service Time	70.00	45.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	78.0	115.00	
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Median Total Time	**326.00**	**368.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of ınagement options that must be considered	3.50	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.25
Urgency of medical decision making	3.75	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	3.88
Physical effort required	3.38	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.00
Outcome depends on the skill and judgment of physician	3.25	3.00
Estimated risk of malpractice suit with poor outcome	4.00	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.88
Intra-Service intensity/complexity	3.25	3.00
Post-Service intensity/complexity	2.88	2.25

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

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Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23670, we recommend 14.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23670 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

ɔde 23670 requires an extensive approach to accurately reduce and stabilize the humeral neck fracture. The ,uberosity(s) are typically also fractured, displaced and require reduction and fixation. Although the intra-time is longer for key reference code 23420, the complexity and intensity of the intra-operative work for 23670 is greater. The consensus panel believes the overall total work for 23670 is only slightly less than 23420 and is similar to 27626 and 25575. It is also less work than 23680. Post-operatively, hospital work is required to evaluate the neurovascular status, change the operative dressing, remove the Hemovac if inserted, adjust the sling and abduction pillow and review the

post-operative motion and care instructions. Multiple office visits are required to evaluate the wound and neurovascular status, remove the sutures, review the post-operative instructions including range of motion and active motion limitations, obtain an X-ray and review the findings. Any medications prescriptions are renewed and physical therapy is discussed. Maintenance of the joint reduction while attempting to restore early motion is critical during the entire post-operative/global period. The second visit is to assure proper wound healing, re-evaluate the neurovascular status, ar assess ROM. The third and fourth visits are to check the wound, neurovascular status, a X-ray is obtained a reviewed, increases in the active motions and gentle resistance exercises and increase the activities of daily living/recreation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 55% No 45%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 92%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change 8%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 17% no change 92%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23670

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		84.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:23680 Tracking Number F9 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male suffers a fracture dislocation of the shoulder requiring open reduction and internal fixation of the displaced humeral neck fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle or the patient is placed in the beach chair position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the proximal humerus in the deltopectoral interval. Hemostasis is meticulously controlled with electrocautery. The cephalic vein is retracted with either the deltoid or the pectoralis and protected throughout the case. The humeral head position is noted. The capsuloligamentous structures and the rotator cuff are evaluated and released as needed to carefully reduce the humeral head. Avoidance of further injury to the articular surface is mandatory during the reduction procedure. Any loose fragments are removed from the joint space. Attention is then turned to the humeral fracture. Often an interfragmentary screw and/or reduction K wires are required to maintain the reduction while plates and/or screws are placed to stabilize the fracture. Multiple plating and screw configurations are possible. Because of the proximity of the neurovascular structures extreme caution is exercised to protect these structures. Once the fracture is reduced and secured with plate and screws the wound is copiously irrigated with antibiotic saline. The periosteum, capsule and musculotendinous units are repaired and the wound is closed in multiple layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.

- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requi removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	23680				
Sample Size:	250	**Resp N:** 23	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**2.00**	5.00	10.00
Survey RVW:	14.00	15.00	**17.00**	20.00	25.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	60.00	90.00	**120.00**	120.00	180.00

CPT Code: 23680

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	20.0	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**
Office time/visit(s):	78.0	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 23680		
		Specialty Recommended
Physician Work RVU:		15.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29827	090	15.44	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; with rotator cuff repair

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 1 Keratoplasty (corneal transplant); penetrating (in aphakia)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

ımber of respondents who choose Key Reference Code: 6 **% of respondents:** 26.0 %

TIME ESTIMATES (Median)

	CPT Code: 23680	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	75.00	75.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	80.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**361.00**	**334.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

˜he number of possible diagnosis and/or the number of ınagement options that must be considered	3.83	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.33
Urgency of medical decision making	3.33	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.50
Physical effort required	2.83	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	2.67
Outcome depends on the skill and judgment of physician	3.83	3.33
Estimated risk of malpractice suit with poor outcome	3.00	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.00
Intra-Service intensity/complexity	3.17	3.17
Post-Service intensity/complexity	4.17	2.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 23680, we recommend 15.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 23680 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

ıe consensus panel compared the work of 23680 to the key reference code 29827 (same pre and intra-op work, and greater post-op work including hospitalization), but felt that total work for both procedures is very similar. The survey 25th percentile is recommended to reflect this perceived similarity. Post-operatively, hospital work is required to evaluate the neurovascular status, change the operative dressing, remove the Hemovac if inserted, adjust the sling and abduction pillow and review the post-operative motion and care instructions. The first office visit is to re-evaluate the wound and neurovascular status, discuss the operative procedure, remove the wound sutures, review the post-operative instructions

including range of motion and active motion limitations, obtain an X-ray and review the findings. Any medications prescriptions are renewed and physical therapy is discussed. Maintenance of the joint reduction while attempting to restore early motion is critical during the entire post-operative/global period. The second visit is to assure proper wound healing, re-evaluate the neurovascular status, and assess ROM. The third and fourth visits are to check the wound, neurovascular status, obtained and reviewed an X-ray, initiate and increase the active motion and gentle resistan exercises and increase the activities of daily living/recreation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 58% No 42%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 45% I do not agree 55%
B. Patients requiring this service are now:
   more complex (more work) 82% less complex (less work) 0% no change 18%
C. The usual site-of-service has changed:
   from outpatient to inpatient 9% from inpatient to outpatient 0% no change 91%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 23680

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		100.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

PT Code:24545 Tracking Number F10 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male suffers an extra-articular distal humerus fracture requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's upper extremity is placed on the surgical hand table, on an arm board or in the cross chest position with the patient supine or in the lateral decubitus position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the posterior distal humerus. The triceps is split and the radial nerve is exposed, isolated and protected. The fracture fragments are identified and reduced. The butterfly fragment, which is frequently associated with this fracture, is also identified and reduced. Multiple intra-fragmentary screws and/or cerclage wires are often required as are medial and lateral column plates. Once the fractures are stabilized, the wounds are copiously irrigated with antibiotic saline. The muscle fascia is repaired and the skin is closed in multiple layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a splint and sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association					
CPT Code:	24545					
Sample Size:	250	**Resp N:**	23	**Response:** 9.2 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	2.00	**3.00**	5.00	15.00
Survey RVW:		10.86	14.00	**15.00**	18.00	25.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**20.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	90.00	**120.00**	120.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				

Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 24545						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	____					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x	99232x	99233x		
Discharge Day Mgmt:	**0.0**	99238x	99239x			
Office time/visit(s):	**0.0**	99211x	12x	13x	14x	15x
Prolonged Services:	**0.0**	99354x	55x	56x	57x	

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	**RUC Time**

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	**RUC Time**

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58150	090	33,064	17.21	**RUC Time**

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 34.7 %

TIME ESTIMATES (Median)

	CPT Code: 24545	Key Reference CPT Code: 25609	Source of Time RUC Time
Median Pre-Service Time	75.00	65.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**361.00**	**358.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	2.88
Urgency of medical decision making	3.25	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.38
Physical effort required	3.38	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.86
Outcome depends on the skill and judgment of physician	3.25	3.14
Estimated risk of malpractice suit with poor outcome	3.13	2.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.88
Intra-Service intensity/complexity	2.88	2.88
Post-Service intensity/complexity	3.25	3.00

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 24545, we recommend 15.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 24545 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This code is similar to the reference code 25609 intensity and complexity with the addition of hospitalization. The consensus panel also believes that 24545 requires the same work as 23615 and requires more work than 23670 and 27826. Post-operatively, hospital work is required to evaluate the neurovascular status, remove the Hemovac if inserted, check the splint, adjust the sling and review the post-operative care instructions. The first office visit is to evaluate the wound and neurovascular status, discuss the operative procedure, remove the wound sutures, review the post-operative instructions including range of motion and active motion limitations, obtain an X-ray and review the findings. Any

medications prescriptions are renewed. Maintenance of the joint reduction while attempting to restore early motion is critical during the entire post-operative/global period. The second visit is to assure proper wound healing, re-evaluate the neurovascular status, and assess ROM. The third and fourth visits are to check the wound, neurovascular status, obtained and reviewed an X-ray, initiate and increase the active motion and gentle resistance exercises and increase the activities of daily living/recreation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 43% No 57%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 30% I do not agree 70%
B. Patients requiring this service are now:
   more complex (more work) 90% less complex (less work) 0% no change 10%
C. The usual site-of-service has changed:
   from outpatient to inpatient 10% from inpatient to outpatient 0% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24545

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		122.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:24546 Tracking Number F11 Specialty Society Recommended RVU: **22.00**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male suffers a distal humerus fracture which extends into the joint requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available - with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's upper extremity is placed on the surgical hand table, on an arm board or in the cross chest position with the patient supine or in the lateral decubitus position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
An incision is made over the posterior, medial or lateral distal humerus depending on the exact configuration of the fracture. An olecranon osteotomy is often required to exposed and reduce the fracture. The olecranon is cut in a V-shaped fashion after a single or dual screws and a tension band wire are pre-positioned in the olecranon before the osteotomy. The radial nerve is exposed, isolated and protected. The fracture fragments are identified and reduced. The articular surfaces are reduced and carefully placed transcondylar screw(s) are required to maintain the reduction of the articular surface. The multiple fragments, which are frequently associated with this fracture, are also identified and reduced. This fracture is often difficult to maintain a reduction, hold the reduction and stabilize the fracture. Multiple intra-fragmentary screws are required as are medial and lateral column plates. The olecranon osteotomy is repaired with the pre-positioned tension band wire and intra-medullary screw(s). Once the fracture is stabilized the wounds are copiously irrigated with antibiotic saline. The muscle fascia is repaired and the skin is closed in multiple layers.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a splint and sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.

- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requi removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007		
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD		
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association		
CPT Code:	24546		
Sample Size: 250	**Resp N:** 27	**Response:** 0.0 %	
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	10.00	20.00
Survey RVW:	10.00	16.34	**22.00**	23.02	30.00
Pre-Service Evaluation Time:			**50.0**		
Pre-Service Positioning Time:			**20.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	60.00	120.00	**150.00**	180.00	240.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00
Office time/visit(s):	102.0	99211x 0.0 12x 1.0 13x 2.0 14x 1.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t. following table, and tab through to the key reference service box.

CPT Code: 24546		
		Specialty Recommended
Physician Work RVU:		22.00
Pre-Service Evaluation Time:		50.0
Pre-Service Positioning Time:		20.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		150.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
23472	090	22.47	RUC Time

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	RUC Time

CPT Descriptor 1 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
63051	090	996	25.38	RUC Time

CPT Descriptor 2 Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 18.5 %

TIME ESTIMATES (Median)

	CPT Code: 24546	Key Reference CPT Code: 23472	Source of Time
Median Pre-Service Time	85.00	7.00	
Median Intra-Service Time	150.00	124.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**448.00**	**423.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.60	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.60
Urgency of medical decision making	4.00	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	4.00
Physical effort required	3.60	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	2.71
Outcome depends on the skill and judgment of physician	4.40	2.57
Estimated risk of malpractice suit with poor outcome	3.60	2.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	2.75
Intra-Service intensity/complexity	3.60	2.88
Post-Service intensity/complexity	3.60	3.13

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 24546, we recommend 22.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 24546 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This is an intra-articular fracture and an extensive exposure of the joint is required. This typically includes osteotomy of the olecranon and later fixation of the osteotomy. Identification, protection, and transposition of the ulnar nerve is usually performed as part of the procedure. Fixation with at least 2 plates and multiple screws is standard. New fixation devices such as locked plates are typically utilized, especially in older patients. Anatomic reduction of the fracture, especially the joint surface, and stable fixation are technically demanding. These are key factors directly related to functional outcome and the prevention of post-traumatic arthritis. Total time for 24546 is similar to key reference code 27447. Intra-time is

greater for 24546, and although more complex, is less intensive. Code 27447 requires more post-operative hospital work. The consensus panel recommends the survey median as an relative reflection of the these differences.

Postoperative close monitoring is required for assessment of the circulation, sensation and motor function of the involved extremity, as well as evaluation and management of pain control. Hospital work involves removal of the immobilizatic device, as well as a dressing changes, with each wound inspection. Physical therapy would be started and a discussi with the patient and therapist regarding the protocol and limitations is necessary. Multiple post-discharge office visits ar necessary for assessment of the wound, suture removal, ROM and review of x-rays. Progress with rehabilitation therapy is evaluated and instructions regarding immobilization, activity, physical therapy, and restrictions would be provided.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 46% No 54%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 8% no change 92%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24546

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		150.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		150.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:24575 Tracking Number F12 Specialty Society Recommended RVU: **11.00**
Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old male suffers a displaced avulsion fracture of the humeral epicondyle requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's upper extremity is placed on the surgical hand table, on an arm board or in the cross chest position with the patient supine or in the lateral decubitus position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:
A medial or lateral incision is made to protect the cutaneous nerves of the elbow. The subcutaneous tissue is dissected with sharp and blunt dissection. The epicondyle and any bony fragments are identified and great care is taken to protect the ligamentous and muscular attachments on the bone. Once the rotation of the fragment(s) is/are solved and the reduction is attained, fixation of the fragment(s) is/are secured. The fixation is extremely variable from plate and screws to K wires or sutures or any combination thereof. Repair of the muscle fascia is completed. The wounds are copiously irrigated with antibiotic saline. The subcutaneous tissue and skin are closed in multiple levels.

Description of Post-Service Work:
Post-service work: in facility
- Application of bulky dressing and a splint and sling.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association					
CPT Code:	24575					
Sample Size:	250	**Resp N:** 27	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	4.00	12.00
Survey RVW:		8.50	10.00	**11.00**	14.00	20.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		45.00	55.00	**60.00**	83.00	100.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				

Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in following table, and tab through to the key reference service box.

CPT Code: 24575		
		Specialty Recommended
Physician Work RVU:		11.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 24575	Key Reference CPT Code: 25608	Source of Time RUC Time
Median Pre-Service Time	75.00	0.00	
Median Intra-Service Time	60.00	65.00	
Median Immediate Post-service Time	30.00	90.00	
Median Critical Care Time	0.0	30.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	85.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**308.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

he number of possible diagnosis and/or the number of management options that must be considered	2.63	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.63
Urgency of medical decision making	2.63	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	2.75	3.00
Physical effort required	2.63	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.75	2.71
Outcome depends on the skill and judgment of physician	2.50	2.57
Estimated risk of malpractice suit with poor outcome	2.63	2.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	2.75
Intra-Service intensity/complexity	2.88	2.88
Post-Service intensity/complexity	3.25	3.13

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

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During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 24575, we recommend 11.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 24575 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This is an elbow fracture code that puts the radial, posterior interosseous, ulnar and cutaneous nerves at risk. Although intra-time for the reference code 25608 is greater, the post-operative work is less because 24575 requires hospitalization to avoid skin issues, swelling and assess neurocirculatory status. Total time is similar for both codes. Close monitoring of neurovascular status is necessary and the first night is spent in the hospital. Post operative hospital visit would include neurovascular check and review of procedure as well as discussion of limitations and care of splint. The first post operative visit would involve splint and stitch removal with reapplication of immobilization. Wound healing would be

assessed as well as fracture reduction with X-rays. The second visit would entail splint removal, assessment of ROM and initiation of motion exercises. The third visit would assess wound healing, ROM, stability and strength with counseling on activities. X-rays would be taken to assess bone healing. The final visit would assess ROM, stability and strength.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for examp' 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 37% No 63%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 29% I do not agree 71%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 29% no change 71%

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Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24575

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		89.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

,PT Code:24579 Tracking Number F13 Specialty Society Recommended RVU: **13.00**
Global Period: 090 RUC Recommended RVU: **13.00**

CPT Descriptor: Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old suffers a displaced humeral condyle fracture requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's upper extremity is placed on the surgical hand table, on an arm board or in the cross chest position with the patient supine or in the lateral decubitus position.
- Indicate areas of skin to be prepped and mark surgical incisions.
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A medial or lateral incision is made to protect the cutaneous nerves of the elbow. The subcutaneous tissue is dissected with sharp and blunt dissection. The condyle and any bony fragments are identified and great care is taken to protect the ligamentous and muscular attachments on the bone. Once the rotation of the fragment(s) is/are solved careful reduction of the articular surface is mandatory. The reduction is maintained often while cartilaginous fragments are positioned and stabilized. Trans-condylar screws or pins are often required as are cartilage fragment resorbable fixation. The fixation is extremely variable from plate and screws to K wires or sutures or any combination thereof but stability of the medial or lateral column is mandatory. Repair of the muscle fascia is completed. The wounds are copiously irrigated with antibiotic saline. The subcutaneous tissue and skin are closed in multiple levels.

Description of Post-Service Work:
Post-service work: in facility
Application of bulky dressing and a splint and sling.
Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS Daniel J. Nagle, MD, FACS William Beach, MD Louis McIntyre, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons American Society of Surgery of the Hand Arthroscopy Association of North America Orthopaedica Trauma Association				
CPT Code:	24579				
Sample Size:	250	**Resp N:** 27	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**2.00**	4.00	12.00
Survey RVW:	10.00	12.00	**13.00**	16.00	23.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	60.00	70.00	**90.00**	95.00	210.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			

Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 24579						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	____					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)

	CPT Code: 24579	Key Reference CPT Code: ____	Source of Time
Median Pre-Service Time	75.00	0.00	
Median Intra-Service Time	90.00	0.00	
Median Immediate Post-service Time	30.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	85.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**338.00**	**0.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.11	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	3.00
Urgency of medical decision making	3.22	3.22

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	3.78
Physical effort required	3.44	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.22	3.00
Outcome depends on the skill and judgment of physician	3.33	3.25
Estimated risk of malpractice suit with poor outcome	2.89	2.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.11
Intra-Service intensity/complexity	2.89	3.00
Post-Service intensity/complexity	3.00	2.89

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that i be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 24579, we recommend 13.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 24579 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

ɔde 24579 is similar to 24575 with the addition of an intraarticular extension involving the entire condylar structure. The ›ame neurovascular structures are at risk with the added complexity of obtaining and holding the articular surface reduced anatomically to maintain joint congruity. The key reference code 25608 has similar in operative time but less total time because it is typically performed as an outpatient. The survey median work RVU correctly accounts for the additional work of 24579 relative to 24575 and 25608. Close monitoring of neurovascular status is necessary and the first night is spent in the hospital. Post operative hospital visits would include neurovascular check and review of

procedure as well as discussion of limitations and care of splint. The first post operative visit would involve splint and stitch removal with reapplication of immobilization. Wound healing would be assessed as well as fracture reduction with X-rays. The second visit would entail splint removal, assessment of ROM and initiation of motion exercises. The third visit would assess wound healing, ROM, stability and strength with counseling on activities. X-rays would be taken to assess bone healing. The final visit would assess ROM, stability and strength.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for exam 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 31% No 69%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 38% I do not agree 63%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 0% no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 25% no change 75%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24579

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		98.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

2005 UTIL	Surveyed or Reference	CPT	DESC	2007 RVW	SPEC REC	IWPUT	NOTES	RUC NEW	RUC NEW	Total Time	Hosp Vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP (992-) P-SD	32	31	38	POST-OFF (992-) 15	14	13	12	11
5,098,625	MPC	99203	Office or other o	1.34	1.34	0.057		1.34	0.057	29	0.0	0.0	4			20	5								
3,228,657	MPC	99204	Office or other o	2.30	2.30	0.065		2.30	0.065	45	0.0	0.0	5			30	10								
16,274	RSL	26600	Closed treatmen	2.48	2.48	0.024		2.48	0.024	93	0.0	4.0	7	2		15	5							4	
3,260,677	MPC	99291	Critical care, eva	4.50	4.50	0.096		4.50	0.096	70	0.0	0.0	15			40	15								
107,426	MPC	64721	Neuroplasty and	4.84	4.84	0.024		4.84	0.024	171	0.5	3.0	20	15	10	25	20			0.5			2	1	
74	RSL	25651	Percutaneous sk	5.68	5.68	0.040		5.68	0.040	190	0.5	4.0	50			30	20			0.5			1	3	
161	survey	26650	Percutaneous sk	5.80	6.00	0.040		6.00	0.040	197	0.5	4.0	30	10	10	30	20			0.5			2	2	
3,621	RSL	28288	Ostectomy, parti	5.81	5.81	0.035		5.81	0.035	169	0.0	5.0	20			30	20						4		1
51,489	RSL	20680	Removal of impl	5.90	5.90	0.056		5.90	0.056	181	0.5	2.0	35	15	15	50	15			0.5				2	
142	survey	28675	Open treatment	2.97	6.00	0.042		6.00	0.042	197	0.5	4.0	30	10	15	30	15			0.5			2	2	
280	survey	28525	Open treatment	3.37	6.00	0.035		6.00	0.035	207	0.5	4.0	35	10	15	30	20			0.5			2	2	
10,371	MPC	11646	Excision, malign	6.21	6.21	0.069		6.21	0.069	128	0.0	1.0	20	5	5	65	10						1		
84	RSL	25671	Percutaneous sk	6.32	6.32	0.038		6.32	0.038	210	0.5	4.0	50			45	25			0.5			1	3	
1,873	survey	26765	Open treatment	4.21	6.60	0.037		6.60	0.037	217	0.5	4.0	35	10	10	45	20			0.5			2	2	
NEW '07	RSL	25109	Excision of tend	6.81	6.81	0.063		6.81	0.063	191	0.5	3.0	25	10	15	40	20			0.5			2	1	
517	survey	26785	Open treatment	4.25	7.45	0.053		7.45	0.053	227	0.5	4.0	40	10	15	45	20			0.5			2	2	
21	RSL	24332	Tenolysis, tricep	7.77	7.77	0.051		7.77	0.051	230	0.5	4.0	50			60	30			0.5			1	3	
105,266	MPC	49505	Repair initial ing	7.88	7.88	0.065		7.88	0.065	198	0.5	2.0	20	15	15	70	20			0.5			1	1	
152	RSL	25652	Open treatment	7.92	7.92	0.056		7.92	0.056	225	0.5	4.0	50			60	25			0.5			1	3	
249	survey	26715	Open treatment	5.79	7.95	0.073		7.95	0.073	220	0.5	4.0	38	10	15	40	20			0.5			2	2	
1,343	survey	26615	Open treatment	5.38	8.00	0.069		8.00	0.069	217	0.5	4.0	35	10	10	45	20			0.5			2	2	
1,001	survey	28645	Open treatment	4.27	8.00	0.070		8.00	0.070	217	0.5	4.0	35	10	15	45	15			0.5			2	2	
57	survey	26685	Open treatment	7.09	8.00	0.053		8.00	0.053	227	0.5	4.0	30	10	10	60	20			0.5			2	2	
448	survey	28505	Open treatment	3.86		0.072				227	0.5	4.0	40	10	15	45	20			0.5			2	2	
1,963	survey	28485	Open treatment	5.77	8.00	0.049		8.00	0.049	242	0.5	4.0	40	10	15	60	20			0.5			2	2	
2,885	RSL	28289	Hallux rigidus co	8.11	8.11	0.069		8.11	0.069	197	0.0	4.0	30			45	30						4		
15,070	MPC	43269	Endoscopic retro	8.20	8.20	0.093		8.20	0.093	141	0.0	0.0	40			71	30								
4,575	RSL	28750	Arthrodesis, grea	8.37	8.37	0.042		8.37	0.042	237	0.0	4.0	40			75	30						4		
1,692	survey	26735	Open treatment	6.03	8.40	0.056		8.40	0.056	237	0.5	4.0	40	10	10	60	20			0.5			2	2	
76,932	MPC	14040	Adjacent tissue t	8.44	8.44	0.050		8.44	0.050	223	0.0	4.0	15	10	5	90	25						2	2	
1,547	survey	27766	Open treatment	8.73	8.50	0.045		8.50	0.045	266	2.0	4.0	40	10	15	45	20		1	1.0			2	2	
13,149	RSL	28292	Correction, hallu	8.72	8.72	0.042		8.72	0.042	245	1.0	4.0	30			60	25			1.0			4		
32,582	RSL	29824	Arthroscopy, sho	8.82	8.82	0.065		8.82	0.065	225	0.5	4.0	48			60	20			0.5			2	2	
85	survey	26665	Open treatment	7.72	9.00	0.067		9.00	0.067	237	0.5	4.0	35	10	15	60	20			0.5			2	2	
1,260	survey	25545	Open treatment	9.09	9.00	0.039		9.00	0.039	286	2.0	4.0	40	10	10	60	30		1	1.0			2	2	
91,000	MPC	14060	Adjacent tissue t	9.07	9.07	0.090		9.07	0.090	183	0.0	4.0	15	10	5	60	15						2	2	
NEW '07	RSL	25607	Open treatment	9.35	9.35	0.052		9.35	0.052	275	0.5	5.0	40	10	15	60	30			0.5			3	2	
6,720	survey	24685	Open treatment	8.92	9.50	0.069		9.50	0.069	252	0.5	4.0	40	15	10	60	30			0.5			2	2	
209	survey	28465	Open treatment	7.13		0.085				257	0.5	4.0	45	10	15	60	30			0.5			2	2	
2,218	survey	27829	Open treatment	5.68	9.50	0.096	Survey da	9.50		271	2.0	4.0	45	10	15	45	20						2	2	
52,156	MPC	50590	Lithotripsy, extra	9.64	9.64	0.080		9.64	0.080	234	0.5	3.0	35	15	13	60	30			0.5			2	1	
4,368	RSL	25115	Radical excision	9.89	9.89	0.050		9.89	0.050	257	0.0	4.0	45			90	30						4		
661	survey	25515	Open treatment	9.37	10.00	0.079		10.00	0.079	247	0.5	4.0	40	10	10	60	30			0.5			2	2	
676	survey	24635	Open treatment	13.56	10.00	0.055		10.00	0.055	291	2.0	4.0	40	10	15	60	30		1	1.0			2	2	
370	survey	25574	Open treatment	7.47	10.00	0.053		10.00	0.053	296	2.0	4.0	45	10	15	60	30		1	1.0			2	2	
2,230,788	MPC	66984	Extracapsular ca	10.36	10.36	0.211		10.36	0.211	162	0.5	4.0	10	5	10	30	10			0.5			2	2	
146	survey	28555	Open treatment	6.42	10.43	0.066	The numb	[illegible]		281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
316	survey	27784	Open treatment	7.41	10.45	0.066		[illegible]	0.066	281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
5,492	survey	27792	Open treatment	7.91	10.50	0.067		[illegible]	0.067	281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
NEW '07	RSL	25608	Open treatment	10.86	10.86	0.052		10.86	0.052	305	0.5	5.0	40	10	15	90	30			0.5			3	2	
268	survey	25628	Open treatment	9.50	11.00	0.065		[illegible]	0.065	277	0.5	4.0	45	10	15	90	20			0.5			2	2	
660	survey	23515	Open treatment	7.47	11.00	0.062		[illegible]	0.062	287	0.5	4.0	40	15	15	90	30			0.5			2	2	
9	survey	27832	Open treatment	6.87	11.00	0.059		[illegible]	0.059	301	2.0	4.0	45	10	15	75	20		1	1.0			2	2	
195	survey	24575	Open treatment	11.02	11.00	0.060		[illegible]	0.060	308	2.0	4.0	45	15	15	60	30		1	1.0			3	1	

2005 UTIL	Surveyed or Reference	CPT	DESC	2007 RVW	SPEC REC	IWPUT	NOTES	RUC NEW	RUC NEW	Total Time	Hosp Vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP (992-) P-SD	32	31	38	POST-OFF (992-) 15	14	13	12	11
933	survey	26746	Open treatment	5.86	11.10	0.058		[redacted]	0.058	303	0.5	5.0	45	10	15	83	30			0.5			3	2	
3,398	MPC	28299	Correction, hallu	11.39	11.39	0.058		11.39	0.058	299	0.5	4.0	75			90	30			0.5			3	1	
873	survey	28615	Open treatment	8.96	11.50	0.056	The numb	[redacted]		323	2.0	6.0		10		60	18		1	1.0				3	
13,957	survey	27814	Open treatment	11.10		0.075				346	2.0	4.0	45	10	15	90	30	1		1.0			2	2	
239	survey	25525	Open treatment	12.69	12.00	0.064	The numb	[redacted]		303	2.0	4.0	45	10	15	70	20		1	1.0				1	
971	survey	23630	Open treatment	7.47	12.00	0.070		[redacted]	0.070	306	2.0	4.0	43	15	15	70	20		1	1.0			3	1	
203	survey	28585	Open treatment	8.17	12.00	0.053	The numb	[redacted]		324	2.0	5.0	45	10	15	75	20		1	1.0				2	
208	survey	27826	Open treatment	8.97		0.091	The numb			328	2.0	4.0	45	15	15	60	30	1		1.0				1	
10,859	MPC	60220	Total thyroid lob	12.29	12.29	0.077		12.29	0.077	275	2.0	2.0	63			90	25		1	1.0			1	1	
152	RSL	28261	Capsulotomy, m	12.91	12.91	0.050		12.91	0.050	343	2.0	4.0	60			103	30		1	1.0			4		
636	survey	24579	Open treatment	11.96	13.00	0.062		[redacted]	0.062	338	2.0	4.0	45	15	15	90	30		1	1.0			3	1	
239	survey	23670	Open treatment	8.02	14.00	0.080		[redacted]	0.080	326	2.0	4.0	40	15	15	90	30		1	1.0			2	2	
7,914	survey	23615	Open treatment	10.93		0.085				338	2.0	4.0	45	15	15	90	30		1	1.0			3	1	
1,337	survey	25575	Open treatment	12.02	14.00	0.059	The numb	[redacted]		342	2.0	5.0	45	10	15	90	30		1	1.0					
NEW '07	RSL	25609	Open treatment	14.12	14.12	0.058		14.12	0.058	358	0.5	6.0	40	10	15	120	30			0.5			4	2	
7,278	survey	27822	Open treatment		14.75	0.076			0.047	353	2.0	4.0	45	10	15	90	30	1		1.0			3	1	
25,915	RSL	23420	Reconstruction c	14.75	14.75	0.054		14.75	0.054	368	2.0	5.0	45			120	30		1	1.0			5		
197	survey	23680	Open treatment	10.30	15.00	0.067		[redacted]	0.067	361	2.0	4.0	45	15	15	120	30		1	1.0			2	2	
1,426	survey	24545	Open treatment	10.88	15.00	0.067		[redacted]	0.067	361	2.0	4.0	40	20	15	120	30		1	1.0			2	2	
1,384	survey	27823	Open treatment			0.072			0.064	366	2.0	4.0	45	15	15	98	30	1		1.0			3	1	
130	survey	25526	Open treatment	13.43	15.00	0.055	The numb	[redacted]		367	2.0	5.0	45	10	15	115	30		1	1.0					
31,681	RSL	29827	Arthroscopy, sho	15.44	15.44	0.083		15.44	0.083	334	0.5	5.0	75			120	40			0.5				5	
863	survey	27827	Open treatment	15.75		0.080	The numb			441	3.0	5.0	55	15	15	120	30	1	1	1.0				1	
355	survey	23585	Open treatment	9.15	16.25	0.067		[redacted]	0.067	407	3.0	4.0	60	23	15	120	33		2	1.0			2	2	
1,163	MPC	65750	Keratoplasty (co	16.60	16.60	0.108		16.60	0.108	288	0.0	6.0	40			90	20						6		
1,331	survey	24546	Open treatment	15.99		0.083	The numb			448	3.0	4.0	50	20	15	150	30	1	1	1.0				1	
33,064	MPC	58150	Total abdominal	17.21	17.21	0.071		17.21	0.071	394	5.0	2.0	45	5	10	120	30	1	3	1.0			2		
218	RSL	27709	Osteotomy; tibia	17.32	17.32	0.093		17.32	0.093	347	3.0	4.0	40	18	10	108	15		2	1.0			2	2	
101,683	RSL	27236	Open treatment	17.43	17.43	0.060		17.43	0.060	473	6.0	4.0	60	15	15	90	30	2	3	1.0			3	1	
999	survey	28415	Open treatment	17.54		0.080	The numb			441	3.0	5.0	55	15	15	120	30	1	1	1.0				1	
55	survey	28420	Open treatment	17.07		0.086	The numb			481	3.0	5.0	60	20	15	150	30	1	1	1.0				1	
6,992	MPC	37215	Transcatheter pl	19.58	19.58	0.122		19.58	0.122	347	2.0	2.0	60	15	15	103	30	1		1.0			2		
1,118	survey	27828	Open treatment	18.19		0.091	The numb			471	3.0	5.0	55	15	15	150	30	1	1	1.0				1	
412	RSL	28705	Arthrodesis; pan	20.12	20.12	0.058		20.12	0.058	490	3.0	4.0	75			180	35	1	1	1.0		1	2	1	
4,678	survey	23616	Open treatment	21.68	21.00	0.097	The numb	[redacted]		413	3.0	4.0	50	15	15	120	30	1	1	1.0				1	
370	survey	28445	Open treatment			0.092		[redacted]	0.059	444	3.0	5.0	58	15	15	120	30	1	1	1.0				1	
2,260	MPC	50546	Laparoscopy, su	21.69	21.69	0.064		21.69	0.064	467	4.0	3.0	60			205	18		3	1.0		1	2		
16,470	RSL	23472	Arthroplasty, gle	22.47	22.47	0.079		22.47	0.079	458	4.0	4.0	60			165	30	1	2	1.0			3	1	
382,332	RSL	27447	Arthroplasty, kne	23.04	23.04	0.099		23.04	0.099	469	5.0	4.0	45	15	15	124	30	1	3	1.0		1	2	1	
996	MPC	63051	Laminoplasty, ce	25.38	25.38	0.086		25.38	0.086	495	4.0	3.0	55	25	15	190	30	1	2	1.0			2	1	
11,399	MPC	44204	Laparoscopy, su	26.29	26.29	0.097		26.29	0.097	455	5.0	3.0	45			180	30	1	3	1.0			2	1	
18,866	RSL	27487	Revision of total	26.91	26.91	0.081		26.91	0.081	520	6.0	4.0	60			200	30		5	1.0			4		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Epicondylitis Procedures

The CPT Editorial Panel, in February 2007, replaced the existing five epicondylitis procedure codes with three clearer descriptions of the services. The Panel agreed that the five descriptions are confusing, difficult to specify varied situations, and, in some cases, clinically irrelevant. The three new codes, which describe the same work, were developed to clearly describe the work involved in the epicondylitis procedures as well as additional work that may or may not be required in such procedures.

24357

The RUC discussed the specialty societies' survey results and presentation for 24357, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous*. The new code was compared to reference service 25651, *Percutaneous skeletal fixation of ulnar styloid fracture*, (work RVU = 5.68). The two services have identical intra-service time (20 minutes), while the surveyed code requires slightly less intensity and complexity. As such, the specialty society and the RUC agreed that the survey median of 5.68 RVUs was too high. The RUC also compared the service to the code with which it was previously billed, 24350, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis)*, (work RVU = 5.32). Because the service does not represent new work, the RUC agreed that a work RVU of 5.32 was appropriate. Further, 5.32 falls midway between the 25th percentile and the median of the survey results, providing greater rationale for the recommended work RVU. The RUC determined that the single 99213 office visit overstated the work involved in the visit; however, a total of four office visits was appropriate. The RUC, therefore, reduced the single 99213 office visit to a 99212 office visit accounting for a total of four level two office visits within the service's global period. The RUC discussed the pre-service time and noted that the 15 minutes allotted for scrub, dress and wait time was excessive. Subsequently, the RUC recommended a reduction in this pre-service time category to the standard of 10 minutes, reducing total pre-service time to 50 minutes. The RUC recommends a pre-service time of 50 minutes, intra-service time of 20 minutes, and immediate post-service time of 15 minutes as well as one-half 99238 discharge day management and four 99212 office visits for code 24357

The RUC recommends a work RVU of 5.32 for code 24357.

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24358

The RUC discussed the specialty societies' survey results and presentation for 24358, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous; open, debridement, soft tissue and/or bone.* The new code was compared to reference service 25109, *Excision of tendon, forearm and/or wrist, flexor or extensor, each*, (work RVU = 6.81). The two services have identical intra-service and post-service times (intra = 40 and post = 20 minutes), and the surveyed code requires similar intensity and complexity as compared to the reference code. As such, the specialty society and the RUC agreed that the survey median of 6.81 RVUs was too high, while the 25th percentile was too low. The RUC also compared the service to codes with which it was previously billed, 24351, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment*, (work RVU = 5.97), 24352, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection*, (work RVU = 6.49); 24354, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping*, (work RVU = 6.54); and 24356, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy* (work RVU = 6.74). Because the service does not represent new work, the RUC agreed that a weighted average for the previously billed services would assist in the recommendation of an appropriate work RVU (calculation shown below). The resulting work RVU is 6.54. Further, 6.54 falls midway between the 25th percentile and the median of the survey results, providing greater rationale for the recommended work RVU. The RUC determined that the single 99213 office visit overstated the work involved in the visit; however, a total of four office visits was appropriate. The RUC, therefore, reduced the single level three office visit to a 99212 office visit accounting for a total of four 99212 office visits within the service's global period. The RUC discussed the pre-service time and noted that the 15 minutes allotted for scrub, dress and wait time was excessive. Subsequently, the RUC recommended a reduction in this pre-service time category to the standard of 10 minutes, reducing total pre-service time to 50 minutes. The RUC recommends a pre-service time of 50 minutes, intra-service time of 40 minutes, and immediate post-service time of 20 minutes for code 24358.

284

The RUC recommends a work RVU of 6.54 for code 24358.

24358

Surveyed Service	Previously Billed Service	2007 work RVU	2005 Medicare Frequency	Total work RVUs	Work RVU x Freq. %	Weighted Average
~~243X2~~	24351	5.97	326 (24%)	1946	1.43	6.54
	24352	6.49	35 (3%)	227	0.20	
	24354	6.54	68 (5%)	445	0.33	
	24356	6.74	925 (68%)	6235	4.58	
			1,354 (Total)	8,853 (Total)		

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24359

The RUC discussed the specialty societies' survey results and presentation for 24359, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, debridement, soft tissue and/or bone, with tendon repair or reattachment.* The new code was compared to reference service 24343, *Repair lateral collateral ligament, elbow, with local tissue* (work RVU = 8.99). The reference service has a greater amount of intra-service and post-service time as compared to the surveyed code (intra = 90 and 30 minutes and post = 60 and 20 minutes). However, the surveyed code requires greater physical effort, urgency of decision making, and more intense pre-service work. As such, the RUC agreed that the surveyed code should be valued slightly lower than the reference service and agreed with the specialty society recommendation of the 25th percentile of the survey data work RVU of 8.86. The RUC also noted that previously, 24359 would have been billed in one of three ways, 1) using both 24341, *Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)* (work RVU = 9.24) and 24356, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy,* (work RVU = 6.74) resulting in a total work RVU of 12.61 accounting for the multiple procedure reduction; or 2) using both 24341, *Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)* (work RVU = 9.24) and 24351, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment* (work RVU = 5.97), resulting in a total work RVU of 12.23 accounting for the multiple procedure reduction. The recommended value also retains neutrality of work within the family of services. The RUC determined that the single 99213 office visit overstated the work involved in the visit; however, a total of four office visits was appropriate. The RUC, therefore, reduced the single 99213 office visit to a 99212 office visit accounting for a total of four 99212 office visits within the service's global period. The RUC discussed the pre-service time and noted that the 15 minutes allotted for scrub, dress and wait time was excessive. Subsequently, the RUC recommended a reduction in this pre-service time category to the standard of 10 minutes, reducing total pre-service time to 50 minutes. The RUC recommends a pre-service time of 50 minutes, intra-service time of 60 minutes, and immediate post-service time of 20 minutes for code 24359

The RUC recommends a work RVU of 8.86 for code 24359.

Practice Expense

The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

Work Neutrality

The work described in 24357-24359 does not constitute new physician work and is subject to work neutrality constraints. The RUC calculated and determined that the new work RVUs will maintain neutrality of work within the family

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●24357	V1	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous	090	5.32
●24358	V2	open, debridement, soft tissue and/or bone	090	6.54
●24359	V3	open, debridement, soft tissue and/or bone, with tendon repair or reattachment (Do not report 24357-24359 in conjunction with 29837, 29838)	090	8.86
D 24350		~~Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis);~~	090	N/A
D 24351		~~with extensor origin detachment~~	090	N/A
D 24352		~~with annular ligament resection~~	090	N/A
D 24354		~~with stripping~~	090	N/A
D 24356		~~with partial ostectomy~~ (24350-24356 have been deleted. To report, see 24357-24359)	090	N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24357 Tracking Number V1 Specialty Society Recommended RVU: **5.32**
Global Period: 090 RUC Recommended RVU: **5.32**

CPT Descriptor: Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with lateral epicondylitis undergoes a percutaneous tenotomy of the proximal extensor carpi radialis at its lateral epicondylar insertion.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation rapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an incision is made over the lateral epicondyle. The scalpel blade is advanced to the proximal tendon of the extensor carpi radialis brevis. The blade is then swept across the tendon sectioning the tendon. The fingers and wrist are flexed with the forearm held in pronation to separate the tendon from the lateral epicondyle. The skin is closed.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart

- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office
- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS					
Specialty(s):	AAOS, ASES, ASSH					
CPT Code:	24357					
Sample Size:	200	**Resp N:**	44	**Response:** 22.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	0.00	12.00
Survey RVW:		4.00	5.00	**5.68**	6.58	8.86
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		10.00	15.00	**20.00**	20.00	60.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 24357	
	Specialty Recommended
Physician Work RVU:	**5.32**
Pre-Service Evaluation Time:	**30.0**
Pre-Service Positioning Time:	**10.0**
Pre-Service Scrub, Dress, Wait Time:	**10.0**
Intra-Service Time:	**20.00**

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**64.0**	99211x **0.0** 12x **4.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

; the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25651	090	5.68	**RUC Time**

CPT Descriptor Percutaneous skeletal fixation of ulnar styloid fracture

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)	CPT Code: 24357	Key Reference CPT Code: 25651	Source of Time RUC Time
Median Pre-Service Time	50.00	50.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	64.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**168.00**	**190.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.64	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.45	2.40
Urgency of medical decision making	1.82	2.10
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.18	2.56
Physical effort required	1.91	2.11
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.27	2.44
Outcome depends on the skill and judgment of physician	3.18	3.00
Estimated risk of malpractice suit with poor outcome	2.82	2.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.20	2.11
Intra-Service intensity/complexity	2.00	2.33
Post-Service intensity/complexity	2.10	2.22

Additional Rationale

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

CPT recently deleted five CPT codes and approve three new CPT codes to better describe surgical procedures in the elbow. The three new codes required RUC surveys to develop physician work RVUs.

A survey for 24357 was sent to orthopaedic surgeons representing general orthopaedics, shoulder & elbow surgery, and hand surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

New code 24357 would have previously been billed as deleted code 24350. The current value for 24350 is 5.32 and should be maintained because this is not a 5YR issue and budget neutrality applies. The key reference code 25651 reflects comparable work.

				2007 RVW	2005 Freq
24357	reported as	**24350**	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis);	5.32	419

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
24350 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis);

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

Specialty ortho How often? Rarely

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 419
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. this is the frequency for 24350

Specialty ortho Frequency 400 Percentage 95.46 %

Specialty plastic Frequency 19 Percentage 4.53 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24358 Tracking Number V2 Specialty Society Recommended RVU: **6.54**
Global Period: 090 RUC Recommended RVU: **6.54**

CPT Descriptor: Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, with debridement of soft tissue and/or bone

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with lateral epicondylitis undergoes debridement of the degenerated proximal extensor carpi radialis brevis tendon.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an incision is made over the lateral epicondyle. The fascia is incised. The proximal tendon of the extensor carpi radialis brevis is identified. Care is taken to avoid injuring the radial nerve. The degenerative myxoid tissue is completely excised. The soft tissues are removed from the insertion of the extensor carpi radialis brevis on the lateral condyle. Multiple drill holes are made in the exposed surface of the lateral epicondyle. The wound is irrigated. The fascia is then repaired. The skin is closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders. Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS					
Specialty(s):	AAOS, ASES, ASSH					
CPT Code:	24358					
Sample Size:	200	**Resp N:**	44	**Response:** 22.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**4.00**	6.00	30.00
Survey RVW:		5.00	6.00	**7.28**	8.05	10.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		20.00	30.00	**40.00**	45.00	60.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 24358		
		Specialty Recommended
Physician Work RVU:		**6.54**
Pre-Service Evaluation Time:		**30.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**10.0**
Intra-Service Time:		**40.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**64.0**	99211x **0.0** 12x **4.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

s the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25109	090	6.81	**RUC Time**

CPT Descriptor Excision of tendon, forearm and/or wrist, flexor or extensor, each

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)	CPT Code: 24358	Key Reference CPT Code: 25109	Source of Time RUC Time
Median Pre-Service Time	50.00	50.00	
Median Intra-Service Time	40.00	40.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	64.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**193.00**	**191.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.64	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.45	2.75
Urgency of medical decision making	2.18	2.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.91	3.00
Physical effort required	2.36	2.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.64	2.38
Outcome depends on the skill and judgment of physician	3.00	2.75
Estimated risk of malpractice suit with poor outcome	2.55	2.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.73	2.63
Intra-Service intensity/complexity	2.91	2.88
Post-Service intensity/complexity	2.73	2.75

Additional Rationale

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

CPT recently deleted five CPT codes and approve three new CPT codes to better describe surgical procedures in the elbow. The three new codes required RUC surveys to develop physician work RVUs.

A survey for 24358 was sent to orthopaedic surgeons representing general orthopaedics, shoulder & elbow surgery, and hand surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

New code 24358 would have previously been billed as any one of the deleted codes 24351-24356. The current values for these codes range from 5.97 to 6.74. However, because this is not a 5YR issue and budget neutrality applies, a weight average of all four codes, using current values and Medicare frequency was calculated. An RVW of 6.54 is recommended.

				A	B	A x B	
				2007 RVW	2005 Freq	RVWs	REC Avg RVW
24358	reported as any one of these codes	24351	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment	5.97	326	1,946	
		24352	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection	6.49	35	227	
		24354	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping	6.54	68	445	
		24356	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy	6.74	925	6,235	
					1,354	8,853	6.54

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

24351 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment
24352 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection
24354 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping
24356 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy
24999 Unlisted procedure, humerus or elbow

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

Specialty ortho How often? Sometimes

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. % of total frequncy for 24351, -52, -54, -56

Specialty ortho Frequency 800 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24359 Tracking Number V3 Specialty Society Recommended RVU: **8.86**
Global Period: 090 RUC Recommended RVU: **8.86**

CPT Descriptor: Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, with debridement of soft tissue and/or bone, with tendon repair or reattachment

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with lateral epicondylitis undergoes debridement of the degenerated proximal extensor carpi radialis brevis tendon followed by reattachment of the residual extensor carpi radialis.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatio. drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an incision is made over the lateral epicondyle. The fascia is incised. The proximal tendon of the extensor carpi radialis brevis is identified. Care is taken to avoid injuring the radial nerve. The degenerative myxoid tissue is completely excised. The soft tissues are removed from the insertion of the extensor carpi radialis brevis on the lateral condyle. Bone anchors are placed in the exposed lateral epicondyle. The sutures of the bone anchors are passed through the residual proximal extensor carpi radialis brevis tendon. The residual proximal extensor carpi radialis brevis tendon is then reattached to the lateral epicondyle. The wound is irrigated. The fascia is then repaired. The skin is closed in layers

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD, FACS				
Specialty(s):	AAOS, ASES, ASSH				
CPT Code:	24359				
Sample Size: 200	**Resp N:** 44	**Response:** 22.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**5.00**	10.00	25.00
Survey RVW:	6.90	8.86	**9.00**	9.00	12.00
Pre-Service Evaluation Time:			**30.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	30.00	45.00	**60.00**	60.00	75.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the new technology/service box.

CPT Code: 24359	
	Specialty Recommended
Physician Work RVU:	8.86
Pre-Service Evaluation Time:	30.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	10.0
Intra-Service Time:	60.00
Immediate Post Service-Time:	20.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	64.0	99211x 0.0 12x 4.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24343	090	8.99	RUC Time

CPT Descriptor Repair lateral collateral ligament, elbow, with local tissue

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 59.0 %

TIME ESTIMATES (Median)

	CPT Code: 24359	Key Reference CPT Code: 24343	Source of Time RUC Time
Median Pre-Service Time	50.00	55.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	64.0	87.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**213.00**	**281.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.96	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	3.06
Urgency of medical decision making	2.08	0.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.35	3.53
Physical effort required	2.92	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.08	3.12
Outcome depends on the skill and judgment of physician	3.54	3.47
Estimated risk of malpractice suit with poor outcome	2.73	2.82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.16	3.06
Intra-Service intensity/complexity	3.20	3.31
Post-Service intensity/complexity	2.76	2.81

Additional Rationale

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

CPT recently deleted five CPT codes and approve three new CPT codes to better describe surgical procedures in the elbow. The three new codes required RUC surveys to develop physician work RVUs.

A survey for 24359 was sent to orthopaedic surgeons representing general orthopaedics, shoulder & elbow surgery, and hand surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine reviewed the survey data compared with the reference code and other orthopaedic services.

New code 24359 would have previously been billed using multiple procedures (24341+24356 or 24341+24351) - note that each of these procedures has allowed claims that use the -51 modifier, or alternatively, 24999 Unlisted humerus or elbow. The RVWs for the multiple procedure combinations are 12.23 and 12.61.

A	24359	reported as		**BONE DEBRIDEMENT AND TENDON REPAIR/REATTACHMENT**	**12.61**
		and	24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	9.24
			24356	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy	6.74
OR					
B	24359	reported as		**SOFT TISSUE DEBRIDEMENT AND TENDON REPAIR/REATTACHMENT**	**12.23**
		and	24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	9.24
			24351	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment	5.97
OR					
C	24359	reported as	24999	Unlisted, humerus or elbow.	carrier

However, the survey 25th pctl of 8.86 is recommended to set the new code relative to the key reference code 24343. This value will always be less than previously reported, and therefore meets budget neutrality criteria outside of a 5YR.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

BONE DEBRIDEMENT AND TENDON REPAIR/REATTACHMENT

24341-51 Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)

24356-51 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy

or

SOFT TISSUE DEBRIDEMENT AND TENDON REPAIR/REATTACHMENT

24341-51 Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)

24354-51 Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping

or

unlisted, by report

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

Specialty ortho How often? Sometimes

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Plea
explain the rationale for this estimate. frequency of combination codes with modifier-51 and unlisted

Specialty ortho Frequency 400 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

24357 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous

24358 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, with debridement of soft tissue and/or bone

24359 Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, with debridement of soft tissue and/or bone, with tendon repair or reattachment

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 6 minutes has been applied for these outpatient procedures for discharge day management services.

Post-Service Clinical Labor Activities:

The procedures each have 3 x 99212 and 1 x 99213 visit. The standard times have been applied for post-service clinical labor time.

	A	B	C	D	E	F	G	H	I
1				24357		24358		24359	
2	**April 2007 AMA/Specialty Society RVS Update Committee Recommendation**			Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous		Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, with debridement of soft tissue and/or bone		Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, with debridement of soft tissue and/or bone, with tendon repair or reattachment	
3	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90	N/A	90	N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	174	N/A	174	N/A	174
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6	N/A	6	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	108	N/A	108	N/A	108
9	PRE-SERVICE								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	SERVICE PERIOD								
39	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D	RN/LPN/MTA		6		6		6
41	**End: Patient leaves office/FACILITY**								
42	POST-SERVICE Period								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27		4		4		4
49	99213 36 minutes	L037D	36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
53									
54	*Total Office Visit Time*			0	108	0	108	0	108
55	Other Activity (please specify)								
56	**End: with last office visit before end of global period**								
57	MEDICAL SUPPLIES	CMS Code	Unit						
58	pack, minimum multi-specialty visit	SA048	pack		4		4		4
59	pack, post-op incision care (suture)	SA054	kit		1		1		1
60									
61									
62	Equipment	CMS Code	Utilization Percentage						
63	table, power	EF031	100%		117		117		117
64	light, exam	EQ168	100%		117		117		117

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Internal or External Fixation-Elbow/Hand

As part of the 2005 Five Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2007 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty that these codes needed to be clarified and removed reference to external fixation from 64 CPT codes. These 64 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. The Hip/Knee codes will be discussed at the April 2007 RUC Meeting.

Between 225 and 450 orthopaedic providers participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, shoulder and elbow surgery, orthopaedic trauma surgery and general hand surgery. After the results from all of these groups were tabulated, a consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America and Orthopaedic Trauama Association met to discuss the survey data for the revised orthopaedic codes. During this review, the specialties determined that they would recommend the 25th percentile for codes in situations where all of the fracture codes, when they were arrayed in order of complexity, it was rational to recommend the 25th percentile RVU value as a means to maintain rank order. Furthermore, the specialty

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societies reviewed the resulting IWPUTs associated with the revised codes and determined that these IWPUT values validated the recommended work RVUs.

The RUC reviewed the compelling evidence for these procedures. The specialty societies claimed that because the CPT descriptors originally contained the phrase "with or without internal or external fixation," it is difficult to imagine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs.

Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. There are also new internal fixation devices which require more work. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. Also, for several of the identified procedures, the provider of the services have changed and were not a part of the original Harvard studies such as the American Society for Surgery of the Hand. The specialty societies conducted a full RUC survey of all codes, and for almost all of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending reductions in work RVUs for three codes of the codes in this family, 24635, 25545 and 25525.

The RUC thoroughly reviewed these codes, and as part of this review, the specialties explained that they felt strongly that a 99214 office visit was appropriate for two of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99213 office visit. The RUC also reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)*. It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲24635	F14	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	10.00
▲24665	F15	Open treatment of radial head or neck fracture, ~~with or without~~ includes internal fixation or radial head excision, when performed;	090	Specialty Society Request to Defer this Procedure to CPT for Clarification
24666	F16	Open treatment of radial head or neck fracture, ~~with or without~~ internal fixation or radial head excision; with radial head prosthetic replacement	090	Specialty Society Request to Defer this Procedure to CPT for Clarification
▲24685	F17	Open treatment of ulnar fracture proximal end (olecranon process), ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	9.50
▲25515	F18	Open treatment of radial shaft fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	10.00
▲25525	F19	Open treatment of radial shaft fracture, includes ~~with~~ internal ~~and/ or external~~ fixation, when performed, and closed treatment ~~of dislocation~~ of distal radioulnar joint dislocation (Galeazzi fracture/dislocation), includes ~~with or without~~ percutaneous skeletal fixation, when performed	090	12.00
▲25526	F20	Open treatment of radial shaft fracture, with internal ~~and/or external~~ fixation, when performed and open treatment, ~~with or without~~ includes internal or external fixation, when performed of distal radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	090	15.00

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▲25545	F21	Open treatment of ulnar shaft fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	9.00
▲25574	F22	Open treatment of radial AND ulnar shaft fractures, with internal ~~or external~~ fixation, when performed; of radius OR ulna	090	10.00
▲25575	F23	Open treatment of radial AND ulnar shaft fractures, with internal ~~or external~~ fixation, when performed; of radius AND ulna	090	14.00
D 25620		~~Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation~~ (Action at October 2005 CPT Meeting)	090	N/A
▲25628	F24	Open treatment of carpal scaphoid (navicular) fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	11.00
▲26615	F25	Open treatment of metacarpal fracture, single, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each bone	090	8.00
▲26650	F26	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, ~~with or without external fixation~~	090	6.00
▲26665	F27	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	9.00
▲26685	F28	Open treatment of carpometacarpal dislocation, other than thumb; ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each joint	090	8.00
▲26715	F29	Open treatment of metacarpophalangeal dislocation, single, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	7.95

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▲26735	F30	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each	090	8.40
▲26746	F31	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each	090	11.10
▲26765	F32	Open treatment of distal phalangeal fracture, finger or thumb, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each	090	6.60
▲26785	F33	Open treatment of interphalangeal joint dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, single	090	7.45

NOT IN RUC Database

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AMA/Specialty Society RVS Update Committee
RUC Recommendations - Internal or External Fixation
CPT Code Order

CPT Code	*Descriptor*	*Global*	*RUC Rec Work RVU*	*RUC Rationale*
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 23515 Open treatment of clavicular fracture, includes internal fixation, when performed and compared it to its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC compared the intra-service times for these procedures and noted that 23515 had less intra-service time associated with it as compared to 29827, 90 and 120 minutes, respectively. The RUC compared the intensity complexity measures of 23515 amd 29827 and noted that the reference code required more technical skill to perform and had a more intense intra-service period as compared to 23515. Therefore, the RUC agreed that the median of the survey data, 11.00 RVUs, appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 23515 as 28299 has slightly more total service time associated with it in comparison to 23515, 299 minutes and 287 minutes respectively. The RUC recommends 11.00 RVUs for 23515.
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation	090	16.25	The RUC reviewed CPTcode 23585 Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation and compared it to its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC noted that the total service time for the surveyed code was lower than the reference code, 407 minutes and 469 minutes respectively. Furthermore, the RUC compared the intensities of these procedures and determined that because, 23585 is one of the most complex of the procedures performed for reduction and internal fixation of shoulder fractures and typically requires an extensive exposure of the scapula with significant muscle disection and identification and protection of the suprascapular nerve and artery, it was deemed a more intensive procedure than the reference code 27447. However, the RUC agreed that to keep this code in proper rank order with other codes in the family, such as 23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed (RUC recommended value of 15.00 RVUs) and 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement (RUC recommended value of 21.00 RVUs), the value associated with this procedure should be the 25th percentile of the survey, 16.25 RVUs. The RUC recommends 16.25 RVUs for 23585.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	090	14.00	The RUC reviewed CPT code 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; and compared it with its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC noted that the surveyed code has significantly less intra-service time associated with it as compared to the reference code, 90 minutes and 130 minutes, respectively. Further, the RUC noted that the reference service required more physical effort to perform and has a more complex intra-service period as compared to 23615. The RUC reviewed several other codes under review in this family, such as 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed (RUC Recommended value=14.00 RVUs) 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna (RUC recommended value=14.00). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the 25th percentile of the survey, 14.00 RVU appropriately places this service in comparison to 23670, 25575 and the key reference service 29827. The RUC recommends 14.00 RVU for 23615.
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement	090	21.00	The RUC reviewed CPT code 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement and compared it with its reference code 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (Work RVU=22.47). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. The RUC noted that 23616 has less intra-service time associated with it as compared to the reference code, 120 minutes and 165 minutes, respectively. Although 23472 has longer intra-service times than the surveyed code, with 23616 comminution is frequently present which makes correct positioning of the prosthesis and stable repair of the tuberosity fragments difficult this makes 23616 a very intensive procedure to perform. For further support the RUC reviewed MPC code 50546 Laparoscopy, surgical; nephrectomy, including partial ureterectomy (Work RVU=21.69). The RUC noted that 50546 had a longer intra-service time in comparison to 23616, 205 minutes and 120 minutes, respectively. Therefore, the RUC agreed that the median value of 21.00 RVUs is appropriate and correctly places this code in comparison to the reference code, 23472 and 50546. The RUC noted that the proposed value for this procedure, 21.00 RVUs, is less than the existing value, 21.68 RVUs. The RUC recommends 21.00 RVUs for 23616.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	090	12.00	The RUC reviewed CPT code 23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed and compared it to its reference code 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) (Work RVU=14.75). The RUC noted that the intra-service time of the surveyed code was far less than the intra-service time of the reference code, 70 minutes and 120 minutes. The RUC also noted that although 23630 is a shoulder fracture that commonly occurs in tandem with poor bone quality, making fixation of the fragment difficult and tenuous, the reference code is a more intensive procedure to perform. This comparison of intensity is demonstrated in the intensity measure of the intra-service time associated with the surveyed code, as it is less than the intensity associated with the reference code. Therefore, the RUC recommends the 25th percentile of the survey for this procedure, 12.00 RVUs. For further support, the RUC compared 23630 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 23630 has less intra-service time as compared to 60220, 70 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 23420. The RUC recommends 12.00 RVU for 23630.
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	090	14.00	The RUC reviewed CPT code 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed and compared it with its reference code 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) (Work RVU=14.75). The RUC noted that the surveyed code has significantly less intra-service time associated with it as compared to the reference code, 90 minutes and 120 minutes, respectively. However, all of the intensity and complexity measures demonstrated that the surveyed code was significanly more difficult to perform than the reference code. The RUC reviewed several other codes under review in this family, such as 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (RUC recommended value of 14.00 RVUs) and 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna (RUC recommended value of 14.00 RVUs). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the 25th percentile of the survey, 14.00 RVU appropriately places this service in comparison to 23615, 25575 and the key reference service 23420. The RUC recommends 14.00 RVU for 23670.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	090	15.00	The RUC reviewed CPT code 23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed and compared it to its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC noted that 23680 and 29827 have the same pre-service time (75 minutes) and intra-service time (120 minutes). The RUC agreed that that in addition to the times for these two procedures being the same that the complexity and work associated with them is similar as well. Therefore the RUC recommends the 25th percentile of the survey 15.00 RVUs to reflect this similarity in service times and work. The RUC recommends 15.00 RVUs for 23680.
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	090	15.00	The RUC reviewed CPT code 24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC reviewed the total-service times for both codes and found them to be comparable, 361 minutes and 358 minutes. However, the RUC noted that the intensity/complexity measures for 24545 were significantly higher in comparison to 25609 as the complexity and risk for complication involved in 24545 is much greater than 25609. Therefore the RUC agreed that the median value of 15.00 RVU appropriately places this code in comparison to the reference code. The RUC recommends a work RVU of 15.00 for code 24545.
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	090	17.01	The RUC reviewed CPT code 24546 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension and compared it with its reference code 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (Work RVU=22.47). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and a 99212 office visit being associated with this procedure. However, after comparing 24546 with 23472, the RUC determined that this reference code was not a suitable comparison. The RUC agreed that the better reference code would be 24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension (RUC recommended RVU=15.00 RVUs). The RUC compared the total service times for both procedures and determined at 24546 had a longer intra service time in comparison to 24545, 150 minutes and 120 minutes. The RUC also agreed that the intensity/complexity of performing 24546 is significantly higher that performing 24545 as 24545 is an extra-articular fracture and 24546 is an intra-articular fracture requiring extensive exposure of the joint. Therefore, to calculate the recommended RVUs for this procedure, the RUC started with the 25th percentile of the survey data, 16.34 RVUs and added a work RVU increment of 2.01, the difference in intra-service times between 24546 and 24545 (30 minutes) multiplied by the IWPUT of 24545 (0.067). This calculation results in a value of 17.01 RVUs. The RUC recommends 17.01 RVUs for 24546.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 305 minutes and 308 minutes. Therefore the RUC agreed that the median value of 11.00 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 24575 as 28299 has more intra- service time associated with it in comparison to 24575, 90 minutes and 60 minutes, respectively. The RUC noted that the proposed value for this procedure, 11.00 RVUs, is slightly less than the existing value, 11.02 RVUs. The RUC recommends 11.00 RVUs for 24575.
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	090	13.00	The RUC reviewed CPT code 24579 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed and compared it to 25609 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed (Work RVU=14.12). The RUC noted that the intra-service time for the surveyed code is significantly less than the reference code, 90 minutes and 120 minutes. Furthermore, the RUC noted that the reference code requires more mental effort and judgement and technical skill to perform in comparison to 24579. Because of a lower intra-service time and lower intensity and complexity measures of the surveyed code in comparison to the reference code, the RUC recommends the survey median work RVU, 13.00 RVUs for 24579 as it appropriately places this code in comparison to the reference code. For further support the RUC compared 24579 to 24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed (RUC recommended value=11.00 RVU). The RUC noted that these procedures are similar except 24579 has the addition of an intraarticular extension involving the entire condylar structure. The same neurovascular structures are at risk in 24579 and 24575 except 24579 has the added complexity of obtaining and holding the articular surface reduced anatomically to maintain joint congruity. Because of these comparisons to a reference code and another code within the family, the RUC recommends 13.00 RVUs for 24579.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	090	10.00	The RUC reviewed CPT code 24635 Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the total service time for 24635 is higher than the total service time for 25607, 291 minutes and 275 minutes, respectively. Furthermore, the work for 24635 is greater than 25607 because the dislocated radial head must be treated in addition to the ulna fracture and post-operatively there is a danger of neurovascular injury and compartment syndrome. Close monitoring is required. This is demonstrated in the intensity/complexity measures which indicate that the surveyed code requies greater mental effort and judgement, greater technical skill and greater physical effort to perform in comparison to the reference code. Furthermore, the RUC noted that this service requires a hospital stay as there is significant monitoring of circulation, sensation and motor function of the involved extremity. Therefore, the RUC agreed that the 25th percentile of the survey data, 10.00 work RVUs accurately places this code in comparison to the reference code. The RUC noted that the proposed value for this procedure, 10.00 RVUs, is less than the existing value, 13.56 RVUs. The RUC recommends 10.00 work RVUs for 24635.
24685	Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed	090	9.50	The RUC reviewed CPT code 24685 Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that while both services have an intra-service time of 60 minutes, the surveyed procedure is more complex than the reference code as 24685 is intraarticular and 25607 is extraarticular. This complexity of the intra-service is also noted in the intra-service intensity complexity measure which shows that the surveyed code's intra-service period is more intense than the intra-service time associated with the reference code. Furthermore, the intensity/complexity measures indicate that the surveyed code requires greater mental effort and judgment, greater technical skill and greater physical effort to perform in comparison to the reference code. Therefore, the RUC agreed that the 25th percentile of the survey data, 9.50 work RVUs, accurately places this code in comparsion to the reference code. The RUC recommends 9.50 work RVUs for 24685.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	090	10.00	The RUC reviewed CPT code 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, physical effort, mental effort and judgment to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 10.00 work RVU appropriately places 25515 in comparison to the reference code. The RUC recommends 10.00 work RVUs for 25515.
25525	Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed	090	12.00	The RUC reviewed CPT code 25525 Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. With this change, the RUC noted that the total service times for both of these codes are comparable, 303 minutes and 305 minutes. However, the RUC noted that the surveyed code required greater mental effort and judgment and physicial effort to perform in comparison to the reference code. Therefore, due to comparable total service times but greater intensity/complexity measures, the RUC recommends the survey median, 12.00 RVU for this procedure. For further support, the RUC compared 25525 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 25525 has less intra-service time as compared to 60220, 70 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 25608. The RUC noted that the proposed value for this procedure, 12.00 RVUs, is less than the existing value, 12.69 RVUs. The RUC recommends 12.00 RVU for 22525.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25526	Open treatment of radial shaft fracture, with internal fixation, when performed, and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	090	15.00	The RUC reviewed CPT code 25526 Open treatment of radial shaft fracture, with internal fixation, when performed, and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments. The RUC agreed that the specialty society recommended 99214 office visit should be removed and two 99212 office visit should be added as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in two 99213 office visits and three 99212 office visits being associated with this procedure. With these changes, the RUC noted that the surveyed code has more total service time associated with it in comparison to the reference code, 398 minutes and 358 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgement and more physical effort to perform and has a more complex intra-service period as compared to 25609. The difficulty of this procedure can be explained as this is the most complex of the hand procedures reviewed because this procedure consists of two separate procedures, an open reduction internal fixation of the radius which places the radial nerve in danger as well as the radial artery and a separate arthrotomy of the ulnocarpal joint and repair of the triangular fibrocartilage complex. Because of the increased total service time as well as the higher intensity/complexity measures associated with 25526 in comparison to its reference code, the RUC recommends the survey median of 15.00 work RVU for 25526. The RUC recommends 15.00 RVUs for 25526.
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	090	9.00	The RUC reviewed CPT code 25545 Open treatment of ulnar shaft fracture, includes internal fixation, when performed in compairison to 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the surveyed code and the reference code had the same intra-service time, 60 minutes. The RUC noted that 25545 requires a 99231 hospital visit as there is a danger of neurovascular injury and compartment syndrome and close monitoring is needed. The RUC also noted that the reference code requires greater endurance of psychological stress to perform as compared to the surveyed code. The RUC compared this procedure to 26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed (RUC recommended value of 9.00 RVUs) and MPC code 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less (Work RVU=9.07 and noted that because all of these procedures had similar work and the same intra-service time, 60 minutes, that they should all be valued the similarly. Therefore, because of all of these comparisons, the RUC recommends the median survey RVU, 9.00 work RVUs. The RUC noted that the proposed value for this procedure, 9.00 RVUs, is less than the existing value, 9.09 RVUs. The RUC recommends 9.00 Work RVUs for 25545.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	090	10.00	The RUC reviewed CPT code 25574 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, mental effort and judgement to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 10.00 work RVU appropriately places 25574 in comparison to the reference code. The RUC recommends 10.00 work RVUs for 25574.
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	090	14.00	The RUC reviewed CPT code 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna and compared it with its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC agreed that the specialty society recommended 99214 office visit should be removed and two 99212 office visit should be added as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in two 99213 office visits and three 99212 office visits being associated with this procedure. With these changes, the RUC noted that the surveyed code has less total service time associated with it in comparison to the reference code, 342 minutes and 358 minutes, respectively. Further, the RUC noted that the reference service required more technical skill, physical effort and more psychological stress to perform and has a more complex intra-service period as compared to 25609. The RUC reviewed several other codes under review in this family, such as 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed (RUC Recommended wRVU=14.00 RVUs) 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (RUC recommended wRVU=14.00). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the median of the survey, 14.00 RVUs appropriately places this service in comparison to 23670, 23615 and the key reference service 25609. The RUC recommends 14.00 RVUs for 25575.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 25628 Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed and compared it with its reference code 25394 Osteoplasty, carpal bone, shortening (work RVU=10.71). The RUC noted that the total service time for the surveyed code is more than the total service time for the reference code (277 minutes and 250 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the surveyed code required more technical skill, physical and mental effort and judgement to perform than the reference code. With the higher amount of total service time and higher intensity/complexity measures as compared to 25394, the RUC agreed that the 25th percentile of survey, 11.00 work RVU appropriately places 25628 in comparison to the reference code. The RUC recommends 11.00 work RVUs for 25628.
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	090	8.00	The RUC reviewed CPT code 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (work RVU=9.35). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more mental effort and judgement and more psychological stress. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25607, the RUC agreed that the 25th percentile of survey, 8.00 work RVU appropriately places 26615 in comparison to the reference code. The RUC recommends 8.00 work RVUs for 26615.
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with external fixation	090	6.00	The RUC reviewed CPT code 26650 Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with external fixation and compared it to its reference code 25651 Percutaneous skeletal fixation of ulnar styloid fracture (work RVU=5.68). The RUC compared the total service times for these procedures and noted that the surveyed code (197 minutes of total service time) had more total service time associated with it than the 25651 (190 minutes of total service time). The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25651 has one 99213 and three 99212 associated with it, which suggests the surveyed code involves more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/complexity measures which show that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. Therefore, because of the greater total service time and the more intense post-operative visits, the RUC agreed that the median RVU of the survey data appropriately places 26650 in comparison to 25651. The RUC recommends 6.00 RVUs for 26650.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed	090	9.00	The RUC reviewed CPT code 26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed in comparison to 25652 Open treatment of ulnar styloid fracture (Work RVU=7.92). The RUC noted that the surveyed code had a greater total service time associated with it in comparison to the reference code, 237 minutes and 225 minutes, respectively. The RUC also noted that the surveyed procedure requires greater physicial effort and an endurance of greater psychological stress to perform as compared to the reference code. Furthermore, the surveyed code is a more complex procedure to perform than the reference code given the increased intensity of dealing with an intraarticular fracture as demonstrated in the intensity/complexity time measures which shows that surveyed code is a much more intense procedure to perform than the reference code. The RUC agreed that because of the larger total service time and the greater amount of intensity and complexity associated with the surveyed code as compared to the reference code, the RUC recommends the median survey RVU, 9.00 work RVUs. In addition, the RUC agreed this value is appropriate because it has similar work and the same intra-service time as MPC code 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less (Work RVU=9.07). The RUC recommends 9.00 Work RVUs for 26665.
26685	Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint	090	8.00	The RUC reviewed CPT code 26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service times for both procedures are 60 minutes. The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25652 has one 99213 and three 99212 associated with it which suggests the surveyed code has a more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/ complexity measure which shows that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. With the same amount of intra-service time and slightly different office visits as compared to 25652, the RUC agreed that the median of the survey, 8.00 work RVUs appropriately places 26685 in comparison to the reference code, 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone and 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed which all have the same complexity and proposed work RVU. The RUC recommends 8.00 work RVUs for 26685.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	090	7.95	The RUC reviewed CPT code 26715 Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed and compared it to its reference code, 25671 Percutaneous skeletal fixation of distal radioulnar dislocation (Work RVU=6.32). The RUC compared the total service times for these procedures and noted that the surveyed code (220 minutes of total service time) had more total service time associated with it than the 25671 (210 minutes of total service time). The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25651 has one 99213 and three 99212 associated with it which suggests the surveyed code involves more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/ complexity measure which shows that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. Therefore, because of the greater total service time and the more intense post-operative visits, the RUC agreed that the median RVU of the survey data 7.95 work RVUs, appropriately places 26715 in comparison to 25671. Furthermore, the RUC agreed that this value correctly places this procedure in terms of complexity in comparison to other orthopaedic codes such that it is more complex than 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single (RUC recommended work RVU =7.45 work RVU) and has similar complexity to 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC recommended work RVU=8.00). The RUC recommends 7.95 RVUs for 26715.
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	090	8.40	The RUC reviewed CPT code 26735 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more physical effort and more psychological stress to perform than the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 8.40 work RVUs appropriately places 26735 in comparison to the reference code. Furthermore, the RUC compared the surveyed code with MPC code 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (Work RVU=8.44) and agreed that 8.40 RVU was an approriate value for the surveyed code because the surveyed code had similar total-service time as compared to this procedure, 237 minutes and 223 minutes, respectively. The RUC recommends 8.40 work RVUs for 26735.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	090	11.10	The RUC reviewed CPT code 26746 Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 303 minutes and 305 minutes. However, the RUC noted that the intensity/complexity measures for 26746 were significantly higher in comparison to 25608 as the complexity and risk for complication involved in 26746 is much greater than 25608. Therefore the RUC agreed that the median value of 11.10 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.10 work RVUs was appropriate for 26746 as 28299 has more intra- service time associated with it in comparison to 27832, 90 minutes and 83 minutes respectively. The RUC recommends 11.10 RVUs for 26746.
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	090	6.60	The RUC reviewed CPT code 26765 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical effort, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25652, the RUC agreed that the 25th percentile of survey, 6.60 work RVU appropriately places 26765 in comparison to the reference code. The RUC recommends 6.60 work RVUs for 26765.
26785	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single	090	7.45	The RUC reviewed CPT code 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical effort, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25652, the RUC agreed that the 25th percentile of survey, 7.45 work RVU appropriately places 26785 in comparison to the reference code. The RUC recommends 7.45 work RVUs for 26785.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	090	8.50	The RUC reviewed CPT code 27766 Open treatment of medial malleolus fracture, includes internal fixation, when performed and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (work RVU=9.35). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC noted that this procedure requires a 99231 hospital stay because of the risk of post-operative complications. The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, physical effort and more psychological stress to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25607, the RUC agreed that the 25th percentile of survey, 8.50 work RVU appropriately places 27766 in comparison to the reference code. The RUC noted that the proposed value for this procedure, 8.50 RVUs, is less than the existing value, 8.73 RVUs. The RUC recommends 8.50 work RVUs for 27766.
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	10.45	The RUC reviewed CPT code 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the total service time of 27784 is higher than the total service time of the reference code, 281 minutes and 275 minutes, respectively. The RUC reviewed the intensity complexity measures associated with 27784 and 25607. The RUC noted that 27784 requires more technical skill, physical effort and psychological stress to perform than the reference code. With the higher amount of total service time of the surveyed code in comparison to the reference code and the higher intensity/complexity measures of the surveyed code in comparison to the reference code, the RUC agreed that the median of the survey, 10.45 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.45 RVU for 27784 was appropriate as the intra-service time for 27784 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.45 RVUs for 27784.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	090	10.50	The RUC reviewed CPT code 27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the intra-service time of 27792 is significantly less than the intra-service time of the reference code, 60 minutes and 90 minutes, respectively. The RUC also noted that the care for this type of fracture is slightly more complex than 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed (RUC Recommended Value=10.45). With the lower amount of intra-service time of the surveyed code in comparison to the reference code and maintaining the proper rank order between the surveyed code and 27784, the RUC agreed that the median of the survey, 10.50 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.50 RVU for 27792 was appropriate as the intra-service time for 27792 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.50 RVUs for 27792.
27814	Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed	090	11.50	The RUC reviewed CPT code 27814 Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC compared the intra-service times for these procedures and noted that 27814 had less intra-service time associated with it as compared to 25609, 90 and 120 minutes, respectively. The RUC compared the intensity complexity measures of 27814 amd 25609 and noted that the reference code required more physical effort, mental effort and judgement to perform as compared to 23515. Therefore, the RUC agreed that the 25th percentile of the survey data, 11.50 RVUs, appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.50 work RVUs was appropriate for 27814 as 28299 has the less total service time than the 27814, 299 minutes and 346 minutes respectively. The RUC recommends 11.50 RVUs for 27814.
27822	Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	090	12.12	The RUC reviewed CPT code 27822 Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed since the RUC last reviewed it in 2000. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 27822 be maintained at its current value, 12.12.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27823	Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	090	14.26	The RUC reviewed CPT code 27823 Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed since the RUC last reviewed it in 2000. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 27823 be maintained at its current value, 14.26 RVUs.
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	12.00	The RUC reviewed CPT code 27826 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. The RUC noted that the intra-service time of the surveyed code was far less than the intra-service time of the reference code, 60 minutes and 120 minutes. The RUC compared the intensity/complexity mesaures for these procedures and noted that they were comparable. The RUC after revieweing these times and complexity measures associated with the key reference code and the surveyed code agreed that this surveyed code has the same amount of complexity and work as 25525 Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed, 23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed and 25585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed and therefore recommends that this procedure be valued the same as these other reference codes (all three codes RUC recommended RVU=12.00). The RUC recommends 12.00 RVUs for 27826. For further support, the RUC compared 27826 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 27826 has less intra-service time as compared to 60220, 60 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the key reference code, 25609. The RUC recommends 12.00 RVU for 27826.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	090	16.00	The RUC reviewed CPT code 27827 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 27827 with 27447, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed and the RUC recommended that its value be maintained, could now be used as an alternative reference code. The RUC compared the total service times for both procedures and determined at 28445 had a longer total service time in comparison to the surveyed code 485 minutes and 458 minutes. In addition, the RUC agreed that the intensity and complexity of performing 28445 would be greater than performing 27827. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 16.00 RVUs for 27827.
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	090	20.00	The RUC reviewed CPT code 27828 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 27828 with 27447, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed, could now be used as an alternative reference code. The RUC compared the intra-service times for both procedures and determined at 27828 had a longer intra-service time in comparison to the reference code, 150 minutes and 125 minutes. In addition, the RUC agreed that the intensity and complexity of performing 27828 would be greater than performing 28445. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 20.00 RVUs for 27828.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	9.50	The RUC reviewed CPT code 27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation. The RUC noted that although the reference code has more intra-service time compared with it than the reference code, 60 minutes and 45 minutes, respectively, that the surveyed code has more pre-service time associated with it as more time is required in 27829 to evaluate the fracture. The intensity and risk for complication involved in treating the distal tibia fracture is much greater than the intensity and risk for complication involved with 25607. This is demonstrated in the intensity/comlexity measures which demonstrates that 27829 requires more mental effort and judgement, more technical skill and physical effort and is an overall more intense code to perform than 25607. In addition, the surveyed code has more post-operative work in comparison to 25607, because 27829 requires hospitialization to avoid skin issues, swelling and to assess neurocirculatory status. Because of the greater amount of intensity as well as the hospitalization associated with this service, the RUC agreed the 25th percentile of the survey, 9.50 RVUs accurately places this procedure in comparison to the reference code. The RUC recommends 9.50 RVUs for 27829.
27832	Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	090	11.00	The RUC reviewed CPT code 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 301 minutes and 305 minutes. However, the RUC noted that the intensity/complexity measures for 27832 were significantly higher in comparison to 25608 as the complexity and risk for complication involved in open treatment of the trimalleolar ankle fracture is much greater than 25608. Therefore the RUC agreed that the median value of 11.00 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 27832 as 28299 has more intra- service time associated with it in comparison to 27832, 90 minutes and 75 minutes respectively. The RUC recommends 11.00 RVUs for 27832.
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	090	17.54	The RUC reviewed CPT code 28415 Open treatment of calcaneal fracture, includes internal fixation and recommended that a 99214 office visit should be removed and substituted with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. The RUC agreed that the new survey time data for this procedure further validated the existing work RVUs for this procedure and recommend maintaing the value for this code. The RUC recommends that the new surveyed times be applied to this code and maintaining the current work of 17.54 RVUs for 28415.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	090	19.00	The RUC reviewed CPT code 28420 Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft) and compared it with its reference code 27487 Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component (Work RVU=26.91). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 28420 with 27847, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed, could now be used as an alternative reference code as the RUC recommended that the value for this service be maintained at its existing value. The RUC compared the intra-service times for both procedures and determined at 28420 had a longer intra-service time in comparison to the reference code, 150 minutes and 125 minutes. In addition, the RUC agreed that the intensity and complexity of performing 28420 would be greater than performing 28445. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 19.00 RVUs for 28420.
28445	Open treatment of talus fracture, includes internal fixation, when performed	090	17.07	The RUC reviewed CPT code 28445 Open treatment of talus fracture, includes internal fixation, when performed and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 28445 be maintained at its current value, 17.07 RVUs.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	090	9.50	The RUC reviewed CPT code 28465 Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). In addition, the number of post-operative visits is not the same as the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with three 99213 office visits and two 99212, which suggests the surveyed code involves less complex post operative care as compared to the reference code. However, the RUC also compared this procedure to 24685 Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed (RUC recommended work RVU=9.50) and 27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed (RUC Recommended work RVU=9.50). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as compared to 25608, the RUC agreed that 9.50 work RVU appropriately places 28465 in comparison to 25608, 24685 and 27829. The RUC recommends 9.50 work RVUs for 28465.
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	090	8.00	The RUC reviewed CPT code 28485 Open treatment of metatarsal fracture, includes internal fixation, when performed, each and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with three 99213 office visits and one 99212 office visit, which suggests the surveyed code involves less complex post operative care as compared to the reference code. The RUC noted that the reference code required more mental effort and judgement, more technical kill and physical effort and greater psychological stress to perform than the surveyed code. Also, the RUC also compared this procedure to 26615 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint (RUC recommended work RVU=8.00), 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC Recommended work RVU=8.00) and 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone (RUC recommended work RVU=8.00). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as well as the lower intensity and complexity measures as compared to 28299, the RUC agreed that 8.00 work RVU appropriately places 28485 in comparison to 28299, 26685, 28645 and 26615. The RUC recommends 8.00 work RVUs for 28485.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28505	Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed	090	8.00	The RUC reviewed CPT code 28505 Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed and compared it with its reference code 28750 Arthrodesis, great toe; metatarsophalangeal joint (Work RVU=8.37). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 75 minutes, respectively). Additional pre-service time is associated with the surveyed code because this procedure involves the evaluation of a fracture which requires additional positioning and prep time as compared to the reference code. The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code involves less complex post operative care as compared to the reference code. However, the RUC also compared this procedure to 26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint (RUC recommended work RVU=8.00), 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC Recommended work RVU=8.00) and 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone (RUC recommended work RVU=8.00). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as compared to 28750, the RUC agreed that 8.00 work RVU appropriately places 28525 in comparison to 28750, 26685, 28645 and 26615. The RUC recommends 8.00 work RVUs for 28505.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	090	6.00	The RUC reviewed CPT code 28525 Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each and compared it with its reference code 28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint (Work RVU=8.11). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (30 minutes and 45 minutes, respectively). Additional pre-service time is associated with the surveyed code because this procedure involves a fracture with fixation, which requires more positioning and prep time as compared to the reference code. The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code involves a less complex post operative care as compared to the reference code. The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical skill, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 28289, the RUC agreed that the 25th percentile of survey, 6.00 work RVU appropriately places 28525 in comparison to the reference code. Furthermore, the RUC compared the surveyed code with MPC code 11646 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm (Work RVU=6.21) and agreed that 6.00 RVU was an approriate value for the surveyed code because the surveyed code had significantly less intra-service time than this procedure, 30 minutes and 60 minutes, respectively. The RUC recommends 6.00 work RVUs for 28525.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	10.43	The RUC reviewed CPT code 28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed and compared it with its reference code 28261 Capsulotomy, midfoot; with tendon lengthening (Work RVU=12.91). The RUC noted that the intra-service time of 28555 is significantly less than the intra-service time of the reference code, 60 minutes and 103 minutes, respectively. The RUC reviewed the post-operative visits for this service and determined that to make this service comparable to other codes within the family, 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed (RUC recommended work RVU=10.45) and 27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed (RUC recommended work RVU=10.50), that the specialty societies' recommendation of including a 99214 office visit should be removed from the post-operative visits associated with this code as only two 99213 and two 99212 office visits is more typical of the post-operative care for the typical patient. With the lower amount of intra-service time of the surveyed code in comparison to the reference code and the same post-operative visits as 27784 and 27792, the RUC agreed that the 25th percentile of the survey, 10.43 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.43 RVU for 28555 was appropriate as the intra-service time for 28555 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.43 RVUs for 28555.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	090	12.00	The RUC reviewed CPT code 28585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (work RVU=11.39). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and two 99212 office visits being associated with this procedure. With this change, the RUC noted that the total service times for 28585 is greater than the reference code, 324 minutes and 299 minutes. Additionally, the RUC noted that the surveyed code required greater mental effort and judgement and physicial effort to perform in comparison to the reference code. This intensity of this service is much in part due to the joint that is operated on as it is more proximal and involves larger bones as compared to the tarsometatarsal dislocation procedure. Two bones are involved in this type of dislocation and the risk for post-operative complications is high. Therefore, due more total service time and greater intensity/complexity measures as compared to the reference code, the RUC recommends the 25th percentile of the survey, 12.00 RVUs for this procedure. For further support, the RUC compared 28585 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 28585 has less intra-service time as compared to 60220, 75 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 28299. The RUC recommends 12.00 RVUs for 28585.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	11.50	The RUC reviewed CPT code 28615 Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed and compared it to its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). After hearing the specialty societies' presentation for this code agreed that an additional 10 minutes of pre-service evaluation time and an additional 5 minutes of pre-service scrub, dress and wait time was needed to account for the fact that this procedure involves two bones which increases the complexity and risk associated with this procedure and consequently increases the evaluation and scrub, dress and wait time. Furthermore, the RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and two 99212 office visits being associated with this procedure. With these changes, the RUC noted that 28615 had more total service time than the reference code, 323 minutes and and 299 minutes respectively. Further, the surveyed code requires greater technical skill, physicial effort and psychgological stress to perform in comparison to the reference code. Therefore the RUC agreed that the approriate value for this procedure is the 25th percentile of the survey data, 11.50 RVUs as this value appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to 28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed (RUC recommended RVU=10.43). As treating the type of dislocation involved in 28615 is more difficult than treating a dislocation involving a single bone as in 28555, the proposed value of 11.50 RVU appropriately place this procedure in comparison to 28555. The RUC recommends 11.50 RVUs for 28615
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	090	8.00	The RUC reviewed CPT code 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed and compared it with its reference code 28292 Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure (work RVU=8.72). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code has a less complex post operative care as compared to the reference code. The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more technical skill and more psychological stress. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 28292, the RUC agreed that the 25th percentile of survey, 8.00 work RVU appropriately places 28645 in comparison to the reference code. The RUC recommends 8.00 work RVUs for 28645.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	090	6.00	The RUC reviewed CPT code 28675 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed and compared it with 28288 Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head (work RVU=5.81). The RUC compared the service times of both procedures and noted that although the intra-service times are the same (30 minutes), 28675 had considerable more pre-service time associated with it than 28288 (55 minutes and 20 minutes, respectively). The surveyed code has more pre-service time associated with it because in involves a dislocation requiring fixation, which requires additional positioning and prep time. The reference code does not require fixation. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater mental effort and judgement and more overall intensity to perform than the reference code. Therefore, the RUC agreed that because of the greater amount of time and the greater mental effort and judgement associated with the surveyed code in comparison to the reference code, the RUC recommends survey median RVU, 6.00 RVUs for 28675. The RUC recommends 6.00 RVUs for 28675.

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:24635 Tracking Number F14 Specialty Society Recommended RVU: **10.00**
Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male falls and suffers a displaced fracture of the proximal ulnar shaft and a dislocation of the radial head requiring an open reduction and internal fixation of the ulna and closed reduction of the radial head.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made along the subcutaneous border of the ulna. Careful dissection is carried down to the fascia. The fascia between the extensor carpi ulnaris and flexor carpi ulnaris is incised. The periosteum in the region of the ulnar fracture is incised and elevated. The fracture site is cleared of clot and fibrinous material. The fracture is reduced. A plate is put into position and the reduction held with plate holding clamps. The screw holes are then drilled and the screws are inserted. The fascia is then repaired and the wound closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.

The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	24635					
Sample Size:	225	Resp N: 38	Response: 16.8 %			
Sample Type:	Random					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	1.00	**3.00**	5.00	12.00
Survey RVW:		9.00	10.00	**11.50**	14.88	25.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		50.00	60.00	**60.00**	90.00	120.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	20.0	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				

Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

lowever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 24635		
		Specialty Recommended
Physician Work RVU:		10.00
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14060	090	91,000	9.07	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

CPT Descriptor 2 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

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

TIME ESTIMATES (Median)

	CPT Code: 24635	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**291.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	2.75
Urgency of medical decision making	2.93	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	2.83
Physical effort required	3.07	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.93	2.75
Outcome depends on the skill and judgment of physician	2.86	2.92
Estimated risk of malpractice suit with poor outcome	2.71	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.67	2.58
Intra-Service intensity/complexity	2.47	2.42
Post-Service intensity/complexity	3.27	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 24635, we recommend 10.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 24635 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The work for 24635 is slightly greater than the key reference code 25607 because the dislocated radial head must b treated in addition to the ulna fracture and post-operatively there is a danger of neurovascular injury and compartmen syndrome. Close monitoring is needed. The first night is spent in the hospital monitoring the circulation, sensation and motor function of the involved extremity. The first office visit would include removing the long arm splint, inspecting the wounds, evaluation of the circulation, motor and sensory function, discussion of restrictions and operative findings, X-ray, application of a new dressing and cast, instruction in ROM. The second visit would include taking the cast off, removing

the dressing, removing the sutures, inspecting the wounds, evaluation of the circulation, motor and sensory function, X-ray, application of a new dressing and cast, instruction in ROM. The third visit would include removal of the cast, evaluation of the circulation, motor and sensory function, X-ray, and instruction in ROM and referral to OT. The last visit would evaluate the progress in therapy, modify therapy Rx, review X-ray, and discuss limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 59% No 41%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 91% less complex (less work) 0% no change 9%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 27% no change 73%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24635

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		122.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 5.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:24685 Tracking Number F17 Specialty Society Recommended RVU: **9.50**
Global Period: 090 RUC Recommended RVU: **9.50**

CPT Descriptor: Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male suffers a displaced fracture of the olecranon requiring open reduction and internal fixation of the olecranon.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulat. drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the olecranon taking care to avoid the ulnar nerve. The dissection is carried down to the subcutaneous boarder of the ulna. The fracture site is identified. The fibrinous material and clot are removed. The fracture is reduced. Two heavy Kirschner wires a driven across the fractures from proximal to distal passing through the triceps tendon taking care to engage the anterior cortex of the radius. A transverse hole is drilled in the distal fragment along its posterior border. Surgical wire is then passed through this hole and figure of 8 tension band is fabricated. This is tightened down. The Kirschner wires are bent and driven into the proximal ulna taking care to engage the wire. The wound is irrigated and then closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart

All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	24685					
Sample Size:	225	**Resp N:** 42	**Response:** 18.6 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**4.00**	6.00	20.00
Survey RVW:		7.50	9.50	**10.00**	12.00	20.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		30.00	45.00	**60.00**	75.00	120.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t following table, and tab through to the key reference service box.

CPT Code: 24685		
		Specialty Recommended
Physician Work RVU:		9.50
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14060	090	91,000	9.07	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50590	090	52,156	9.64	RUC Time

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 26.1 %

TIME ESTIMATES (Median)

	CPT Code: 24685	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**252.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of nanagement options that must be considered	3.00	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.64
Urgency of medical decision making	2.91	2.64

Technical Skill/Physical Effort (Mean)

Technical skill required	3.09	2.82
Physical effort required	2.82	2.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.64	2.50
Outcome depends on the skill and judgment of physician	2.73	2.60
Estimated risk of malpractice suit with poor outcome	2.36	2.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.45	2.60
Intra-Service intensity/complexity	2.36	2.20
Post-Service intensity/complexity	3.00	2.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 24685, we recommend 9.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 24685 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work is similar to key reference code 25607, however, intra-operatively, 24685 is more complex because it is intraarticular compared with 25607, which is extraarticular. The first postoperative visit would include a dressing change, CMS check; wound check, application of a new splint, X-rays, OT Rx, discussion of restrictions and operative findings. Early ROM is essential and must be monitored closely. The second visit would be similar to the first but the sutures would be removed and there would be less discussion regarding the procedure. The third visit would include liberation

from the splint, new OT Rx, X-rays would be reviewed, new restrictions discussed. The fourth visit would include a check on the ROM and strength progress, X-rays would be reviewed, new restrictions discussed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 54% No 46%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 95% less complex (less work) 5% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 5% from inpatient to outpatient 23% no change 73%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24685

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		89.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25515 Tracking Number F18 Specialty Society Recommended RVU: **10.00**
Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Open treatment of radial shaft fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male falls on his outstretched upper extremity and suffers a fracture of the radial shaft requiring an open reduction and internal fixation of the radius.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An anterior incision is made over the radius. The brachioradialis fascia is identified and incised. The lateral antebrachial cutaneous nerve is protected as is the superficial branch of the radial nerve. The branches of the radial artery are identified and cauterized. While the arm is held in supination, the attachment of the supinator is released. The arm is then pronated and the insertion of the pronator tear is identified and released and the periosteum along the radius is elevated. The fracture is identified. The fracture is cleared of any fibrinous material or clot. The fracture is then reduced. A plate is applied and the plate is held in position using plate holding clamps. The drill holes are then drilled and the screws placed. The periosteum is then repaired are the supinator and pronator teres. The wound is then closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	25515				
Sample Size: 225	**Resp N:** 42	**Response:** 18.6 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	3.00	**5.00**	7.00	30.00
Survey RVW:	8.25	10.00	**10.95**	12.63	20.00
Pre-Service Evaluation Time:			**40.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	40.00	60.00	**60.00**	90.00	120.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25515		
		Specialty Recommended
Physician Work RVU:		10.00
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50590	090	52,156	9.64	RUC Time

CPT Descriptor 1 Lithotripsy, extracorporeal shock wave

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

CPT Descriptor 2 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 28.5 %

TIME ESTIMATES (Median)

	CPT Code: 25515	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**247.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.20
Urgency of medical decision making	3.09	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.27	3.30
Physical effort required	3.27	3.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.27	3.33
Estimated risk of malpractice suit with poor outcome	2.82	2.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.55	2.67
Intra-Service intensity/complexity	2.64	2.78
Post-Service intensity/complexity	3.18	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, th treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25515, we recommend 10.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25515 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work is slightly less than an ORIF of a two part distal radius fracture, 25608.
The first postoperative visit would include a dressing change, CMS check, wound check, application of a new splint, X-rays, OT Rx, discussion of restrictions and operative findings. The second visit would be similar to the first but the sutures would be removed and there would be less discussion regarding the procedure. The third visit would include

liberation from the splint, new OT Rx, X-rays would be reviewed, new restrictions discussed. The fourth visit would include a check on the ROM and strength progress, X-rays would be reviewed, new restrictions discussed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 56% No 44%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 90% less complex (less work) 0% no change 10%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 35% no change 65%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25515

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		102.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25525 Tracking Number F19 Specialty Society Recommended RVU: **12.00**
Global Period: 090 RUC Recommended RVU: **12.00**

CPT Descriptor: Open treatment of radial shaft fracture, with internal fixation, when performed and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old female suffers a fracture of the radial shaft and dislocation of the distal radioulnar joint requiring an open reduction and internal fixation of the radius and a closed reduction and percutaneous fixation of the distal radioulnar joint.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An anterior incision is made over the radius. The brachioradialis fascia is identified and incised. The lateral antebrachial cutaneous nerve is protected as is the superficial branch of the radial nerve. The branches of the radial artery are identified and cauterized. While the arm is held in supination, the attachment of the supinator is released. The arm is then pronated and the insertion of the pronator tear is identified and released and the periosteum along the radius is elevated. The fracture is identified. The fracture is cleared of any fibrinous material or clot. The radial fracture and distal radioulnar joint dislocation are reduced. A plate is applied to the radius and held in position using plate holding clamps. The drill holes are then drilled and the screws placed. Kirschner wires are driven across the distal radioulnar joint holding the reduction. Care is taken to avoid the dorsal branch of the ulnar nerve. Pin caps are applied to the pins. The radial periosteum is then repaired as are the insertion of the supinator and pronator teres. The wound is then closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.

- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	25525					
Sample Size:	450	**Resp N:** 70	**Response:** 15.5 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**3.00**	4.00	35.00
Survey RVW:		6.32	10.86	**12.00**	14.00	25.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		40.00	60.00	**70.00**	90.00	135.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25525		
		Specialty Recommended
Physician Work RVU:		12.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		70.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 1 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 30 **% of respondents:** 42.8 %

TIME ESTIMATES (Median)

	CPT Code: 25525	Key Reference CPT Code: 25608	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	70.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	85.0	0.00	
Prolonged Services Time	0.0	101.00	
Median Total Time	**303.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.37	3.25
Urgency of medical decision making	3.19	3.15

Technical Skill/Physical Effort (Mean)

Technical skill required	3.41	3.45
Physical effort required	3.26	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.19	3.25
Outcome depends on the skill and judgment of physician	3.31	3.40
Estimated risk of malpractice suit with poor outcome	3.08	3.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.19	3.20
Intra-Service intensity/complexity	2.93	2.95
Post-Service intensity/complexity	3.59	3.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

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Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

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Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25525, we recommend 12.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25525 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Code 25525 is less work than the 25526 since the distal radioulnar joint is treated closed with percutaneous pinning. This is less work than a both bone fracture as well. Additional pre-time is needed to consider the radius and the distal radioulnar joint rather than the single region as noted as in the key reference code. Post-operatively there is a significant danger of neurovascular injury and compartment syndrome. Close monitoring is needed. The first night is spent in the hospital monitoring the circulation, sensation and motor function of the involved extremity. The first office visit would include removal of the splint and dressing, redressing, discussion of restrictions and operative findings, splinting or

casting and instruction on range of motion. X-rays would be reviewed. The second visit would be for splint and dressing removal, suture removal, new cast applications, ROM exercises. The third visit would be for cast removal and range of motion exercises, review restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 51% No 49%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 22% I do not agree 78%
B. Patients requiring this service are now:
   more complex (more work) 88% less complex (less work) 0% no change 13%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 34% no change 66%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25525

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		70.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25526 Tracking Number F20 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Open treatment of radial shaft fracture, with internal fixation, when performed and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old female suffers a fracture of the radial shaft and dislocation of the distal radioulnar joint requiring an open reduction and internal fixation of the radius and an open reduction of the distal radioulnar joint and open repair of the triangular fibrocartilage.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An anterior incision is made over the radius. The brachioradialis fascia is identified and incised. The lateral antebrachial cutaneous nerve is protected as is the superficial branch of the radial nerve. The branches of the radial artery are identified and cauterized. While the arm is held in supination, the attachment of the supinator is released. The arm is then pronated and the insertion of the pronator tear is identified and released and the periosteum along the radius is elevated. The fracture is identified. The fracture is cleared of any fibrinous material or clot. A curvilinear incision is made over the dorsal aspect of the distal radioulnar joint. Care is taken to protect the dorsal branch of the ulnar nerve. The fifth dorsal compartment is opened and the extensor digiti quinti is retraced out of the field. The capsule of the distal radioulnar joint and ulnocarpal joint is incised and reflected. The radius and distal radioulnar joint are reduced. A plate is applied to the radius and held in position using plate holding clamps. The dri' holes are then drilled and the screws placed. The peripheral triangular fibrocartilage tear is identified. Drill holes ar made in the fovea at the base of the ulnar styloid. Sutures pass through the peripheral edge of the triangular fibrocartilage and then out through the holes at the base of the fovea. The sutures are then secured to the ulnar aspect of the distal ulna. The stability of the distal radioulnar joint is assessed. The capsule is then repaired taking care to adjust for any capsular redundancy. The wounds are then closed in layers.

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

- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.

Consultation with the family and patient regarding the surgery and postoperative regimen.

- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007		
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD		
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association		
CPT Code:	25526		
Sample Size: 450	**Resp N:** 70	**Response:** 15.5 %	
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**1.00**	3.00	12.00
Survey RVW:	7.92	14.03	**15.00**	16.35	35.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		

CPT Code: 25526

Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		55.00	90.00	**115.00**	120.00	180.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**20.0**	99231x **1.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**38.0**	99238x **1.00**	99239x **0.00**			
Office time/visit(s):	**125.0**	99211x **0.0**	12x **1.0**	13x **3.0**	14x **1.0**	15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0**	55x **0.0**	56x **0.0**	57x **0.0**	

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25526		
		Specialty Recommended
Physician Work RVU:		15.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		115.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	94.0	99211x 0.0 12x 3.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 41 **% of respondents:** 58.5 %

TIME ESTIMATES (Median)

	CPT Code: 25526	Key Reference CPT Code: 25609	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	115.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	94.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**367.00**	**358.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.13	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.38
Urgency of medical decision making	3.68	3.66

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.97
Physical effort required	3.61	3.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.54	3.66
Outcome depends on the skill and judgment of physician	4.11	4.03
Estimated risk of malpractice suit with poor outcome	3.41	3.48

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.45	3.41
Intra-Service intensity/complexity	3.13	3.03
Post-Service intensity/complexity	3.68	3.52

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25526, we recommend 15.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25526 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This is the most complex of the hand procedures reviewed and consists of two separate procedures, an ORIF of th radius which places the radial nerve in danger as well as the radial artery, and a separate arthrotomy of the ulnocarpa joint and repair of the TFCC. Compared with the key reference code, the intra-times are similar. Additional pre-time is needed to consider the radius and the distal radioulnar joint, rather than a single region. Post-operatively there is a significant danger of neurovascular injury and compartment syndrome. Close monitoring is needed. The first night is spent in the hospital monitoring the circulation, sensation and motor function of the involved extremity. The first office

visit would include removal of the splint and dressing, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion. X-rays would be reviewed,. The second visit would be for splint and dressing removal, suture removal, new cast applications, ROM exercises. The third visit would be for cast removal and range of motion exercises, review restrictions. X-rays would be reviewed. The fourth and fifth visits would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 51% No 49%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 26% I do not agree 74%
B. Patients requiring this service are now:
   more complex (more work) 91% less complex (less work) 0% no change 9%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 37% no change 63%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25526

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		115.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 3.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25545 Tracking Number F21 Specialty Society Recommended RVU: **9.00**
Global Period: 090 RUC Recommended RVU: **9.00**

CPT Descriptor: Open treatment of ulnar shaft fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male falls on his outstretched upper extremity and suffers a fracture of the ulnar shaft requiring an open reduction and internal fixation of the ulna.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatio drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made along the subcutaneous border of the ulna. Careful dissection is carried down to the fascia. The fascia between the extensor carpi ulnaris and flexor carpi ulnaris is incised. The periosteum in the region of the ulnar fracture is incised and elevated. The fracture site is cleared of clot and fibrinous material. The fracture is reduced. A plate is put into position and the reduction held with plate holding clamps. The screw holes are then drilled and the screws are inserted. The fascia is then repaired and the wound closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

Dictation of an operative report

- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	25545					
Sample Size:	250	**Resp N:** 42	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**5.00**	7.00	20.00
Survey RVW:		7.00	9.00	**9.50**	10.97	20.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		30.00	45.00	**60.00**	75.00	120.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

CPT Code: 25545

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25545		
		Specialty Recommended
Physician Work RVU:		9.00
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	76,932	8.44	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50590	090	52,156	9.64	RUC Time

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 52.3 %

TIME ESTIMATES (Median)	CPT Code: 25545	Key Reference CPT Code: 25607	Source of Time RUC Time
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**286.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.80	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.63
Urgency of medical decision making	2.75	2.94
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.15	3.06
Physical effort required	2.90	2.88
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.48	2.63
Outcome depends on the skill and judgment of physician	2.62	2.94
Estimated risk of malpractice suit with poor outcome	2.33	2.69

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.30	2.40
Intra-Service intensity/complexity	2.40	2.36
Post-Service intensity/complexity	3.10	3.07

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25545, we recommend 9.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25545 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work is slightly less than key reference code 25607, however, post-operatively there is a danger of neurovascular injury and compartment syndrome and close monitoring is needed. The first night is spent in the hospital monitoring the circulation, sensation and motor function of the involved extremity. The post operative care is similar to that for a radial shaft fracture. The first postoperative visit would include a dressing change, CMS check, wound check, application of a new splint, X-rays, OT Rx, discussion of restrictions and operative findings. The second visit would be similar to the first but the sutures would be removed and there would be less discussion regarding the procedure. The third visit would

include liberation from the splint, new OT Rx, X-rays would be reviewed, new restrictions discussed. The fourth visit would include a check on the ROM and strength progress, X-rays would be reviewed, new restrictions discussed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 34% No 66%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 92%
B. Patients requiring this service are now:
   more complex (more work) 85% less complex (less work) 0% no change 23%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 38% no change 69%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25545

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		95.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25574 Tracking Number F22 Specialty Society Recommended RVU: **10.00**
Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old male suffers a both-bone-fracture of the forearm requiring an open reduction and internal fixation of the radius and a closed reduction of the ulna.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An anterior incision is made over the radius. The brachioradialis fascia is identified and incised. The lateral antebrachial cutaneous nerve is protected as is the superficial branch of the radial nerve. The branches of the radial artery are identified and cauterized. While the arm is held in supination, the attachment of the supinator is released. The arm is then pronated and the insertion of the pronator tear is identified and released and the periosteum along the radius is elevated. The fracture is identified. The fracture is cleared of any fibrinous material or clot. The fracture is then reduced. A plate is applied and the plate is held in position using plate holding clamps. The drill holes are then drilled and the screws placed. The periosteum is then repaired as are the supinator and pronator teres. The wound is then closed in layers.
OR
An incision is made along the subcutaneous border of the ulna. Careful dissection is carried out down to the fascia. The fascia between the extensor carpi ulnaris and flexor carpi ulnaris is incised. The periosteum in the region of the ulna fracture is incised and elevated. The fracture site is cleared of any clot and fibrinous material. The fracture is reduced. A plate is put into position and the reduction held with plate holding clamps. The holes are then drilled for the screws and the screws are applied. The fascia is then repaired and the wound approximated in layers.

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

- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	25574				
Sample Size:	225	**Resp N:** 42	**Response:** 18.6 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate					
Survey RVW:	8.20	9.50	**10.00**	11.00	20.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		

CPT Code: 25574

Intra-Service Time:		40.00	60.00	60.00	75.00	120.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	20.0	99231x 1.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	38.0	99238x 1.00	99239x 0.00			
Office time/visit(s):	78.0	99211x 0.0	12x 2.0	13x 2.0	14x 0.0	15x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25574						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	____					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14060	090	91,000	9.07	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

CPT Descriptor 2 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)

	CPT Code: 25574	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**296.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.20
Urgency of medical decision making	3.16	2.93

Technical Skill/Physical Effort (Mean)

Technical skill required	3.63	3.80
Physical effort required	3.47	3.47

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	3.00
Outcome depends on the skill and judgment of physician	3.15	3.19
Estimated risk of malpractice suit with poor outcome	2.50	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.85	2.75
Intra-Service intensity/complexity	2.30	2.38
Post-Service intensity/complexity	3.50	3.56

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25574, we recommend 10.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25574 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work is slightly less than an ORIF of a two part distal radius fracture, 25608, however, post-operatively there is a danger of neurovascular injury and compartment syndrome and close monitoring is needed. The first night is spent in the hospital monitoring the circulation, sensation and motor function of the involved extremity. The first postoperative office visit would include a dressing change, CMS check, wound check, application of a new splint, X-rays, OT Rx, discussion of restrictions and operative findings. The second visit would be similar to the first but the sutures would be removed and

there would be less discussion regarding the procedure. The third visit would include liberation from the splint, new OT Rx, X-rays would be reviewed, new restrictions discussed. The fourth visit would include a check on the ROM and strength progress, X-rays would be reviewed, new restrictions discussed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 73% No 27%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 93% less complex (less work) 3% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 3% from inpatient to outpatient 40% no change 53%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25574

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25575 Tracking Number F23 Specialty Society Recommended RVU: **14.00**
Global Period: 090 RUC Recommended RVU: **14.00**

CPT Descriptor: Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old male suffers a both-bone-fracture of the forearm requiring an open reduction and internal fixation of the radius and ulna.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatic drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An anterior incision is made over the radius. The brachioradialis fascia is identified and incised. The lateral antebrachial cutaneous nerve is protected as is the superficial branch of the radial nerve. The branches of the radial artery are identified and cauterized. While the arm is held in supination, the attachment of the supinator is released. The arm is then pronated and the insertion of the pronator tear is identified and released and the periosteum along the radius is elevated. The fracture is identified. The fracture is cleared of any fibrinous material or clot. The fracture is then reduced. A plate is applied and the plate is held in position using plate holding clamps. The drill holes are then drilled and the screws placed. The periosteum is then repaired as are the supinator and pronator teres. The wound is then closed in layers. An incision is made along the subcutaneous border of the ulna. Careful dissection is carried out down to the fascia. The fascia between the extensor carpi ulnaris and flexor carpi ulnaris is incised. The periosteum in the region of the ulnar fracture is incised and elevated. The fracture site is cleared of any clot and fibrinous material. The fracture is reduced. A plate is put into position and the reduction held with plat holding clamps. The holes are then drilled for the screws and the screws are applied. The fascia is then repaired and the wound approximated in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint

- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	25575				
Sample Size:	225	**Resp N:** 42	**Response:** 18.6 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**5.00**	8.00	24.00
Survey RVW:	10.00	11.00	**14.00**	15.00	20.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	60.00	90.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x 99232x 1.0 99233x
Discharge Day Mgmt:	0.0	99238x 1.00 99239x
Office time/visit(s):	0.0	99211x 12x 1.0 13x 3.0 14x 1.0 15x
Prolonged Services:	0.0	99354x 55x 56x 57x

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25575		
		Specialty Recommended
Physician Work RVU:		14.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	94.0	99211x 0.0 12x 3.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 57.1 %

TIME ESTIMATES (Median)

	CPT Code: 25575	Key Reference CPT Code: 25609	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	94.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**342.00**	**358.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	3.31
Urgency of medical decision making	3.18	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	3.64	3.88
Physical effort required	3.77	3.94

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.04	3.25
Outcome depends on the skill and judgment of physician	3.52	3.63
Estimated risk of malpractice suit with poor outcome	2.70	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.86	3.06
Intra-Service intensity/complexity	2.50	2.76
Post-Service intensity/complexity	3.48	3.41

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25575, we recommend 14.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25575 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This is the second most complex hand procedure of the hand code family group. It includes two ORIFs through two separate incisions. There is a significant danger of neurovascular injury and compartment syndrome. Compared with the key reference code, total work is similar - the intra-time is less, but the total time is greater with one day in the hospital. Post-operatively there is a significant danger of neurovascular injury and compartment syndrome. Close monitoring is needed. The first night is spent in the hospital monitoring the circulation, sensation and motor function of

the involved extremity. The first office visit would include removal of the splint and dressing, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion. X-rays would be reviewed. The next visit would be for splint and dressing removal, suture removal, new cast applications, ROM exercises. The third visit would be for cast removal and range of motion exercises, review restrictions. X-rays would be reviewed. The fourth and fifth visits would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 53% No 47%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 13% I do not agree 87%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 4% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 30% no change 65%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25575

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 5.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 3.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:25628 Tracking Number F24 Specialty Society Recommended RVU: **11.00**
Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male suffers an acute scaphoid fracture requiring an open reduction and internal fixation of the scaphoid..

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatic drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A curvilinear incision is made over the palmar aspect of the scaphoid passing just radial to the flexor carpi radialis. The palmar branch of the radial artery is identified and ligated. The sheath of the flexor carpi radialis is opened. The dissection is carried down to the radiocarpal capsule which is incised. The scaphoid fracture is identified. It is reduced and held in position using a guide wire. A supplemental stabilization Kirschner wire is placed parallel to this wire. The screw hold is drilled. A screw of the appropriate length is then placed. The two Kirschner wires are removed. The stability is assessed. The capsule is repaired. The subcutaneous suture and skin are closed in layers

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart

All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	25628					
Sample Size:	225	**Resp N:** 42	**Response:** 18.6 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate						
Survey RVW:		8.00	11.00	**13.00**	15.00	20.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		45.00	60.00	**90.00**	90.00	150.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 25628		
		Specialty Recommended
Physician Work RVU:		**11.00**
Pre-Service Evaluation Time:		**45.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**90.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25394	090	10.71	**RUC Time**

CPT Descriptor Osteoplasty, carpal bone, shortening

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	**RUC Time**

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	**RUC Time**

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 21.4 %

TIME ESTIMATES (Median)

	CPT Code: 25628	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	70.00	50.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**277.00**	**250.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	3.00
Urgency of medical decision making	2.71	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	3.71
Physical effort required	3.14	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.13
Outcome depends on the skill and judgment of physician	3.38	3.25
Estimated risk of malpractice suit with poor outcome	2.50	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	2.75
Intra-Service intensity/complexity	2.50	2.38
Post-Service intensity/complexity	3.48	2.88

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 25628, we recommend 11.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 25628 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work is similar to the key reference code. The first postoperative visit would include a dressing change, wound check, CMS check, application of a long arm cast, X-rays, OT Rx for finger and shoulder ROM, discussion of restrictions and operative findings. The second visit would include CMS check, wound check, suture removal, and application of a new long arm cast. The third visit would include cast removal and application of a new short arm cast, OT Rx for elbow

ROM, discussion of restrictions. The fourth visit would include removal of the short arm case, OT Rx for ROM and strengthening, discussion of restrictions.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 60% No 40%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 17% I do not agree 83%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 8%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 33% no change 71%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25628

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		100.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26615 Tracking Number F25 Specialty Society Recommended RVU: **8.00**
Global Period: 090 RUC Recommended RVU: **8.00**

CPT Descriptor: Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 21-year-old male suffers a fracture of his fifth metacarpal requiring an open reduction and internal fixation of a fracture the fifth metacarpal.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the dorsal aspect of the metacarpal. The periosteum of the dorsal aspect of the metacarpal is incised and reflected. The fracture is identified and cleared of any fibrous material and clot. A plate is applied taking care to maintain the proper alignment of the metacarpal. The plate is held in position using plate holding clamps. The screw holes are then drilled and the screws placed. The periosteum is repaired and the skin is repaired in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	26615				
Sample Size:	225	**Resp N:** 33	**Response:** 14.6 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	2.00	5.00	**10.00**	20.00	30.00
Survey RVW:	6.00	8.00	**9.00**	9.50	12.00
Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	30.00	45.00	**45.00**	60.00	90.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

PECIALTY SOCIETY RECOMMENDED DATA

heck here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value nd Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26615		
		Specialty Recommended
Physician Work RVU:		**8.00**
Pre-Service Evaluation Time:		**35.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**10.0**
Intra-Service Time:		**45.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	**RUC Time**

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	**RUC Time**

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
43269	000	15,070	8.20	**RUC Time**

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 26615	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	55.00	65.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**217.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.55
Urgency of medical decision making	3.27	3.55

Technical Skill/Physical Effort (Mean)

Technical skill required	3.64	3.64
Physical effort required	2.91	3.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.18	3.18
Outcome depends on the skill and judgment of physician	3.36	3.27
Estimated risk of malpractice suit with poor outcome	3.18	3.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.82
Intra-Service intensity/complexity	2.55	2.55
Post-Service intensity/complexity	3.36	3.45

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26615, we recommend 8.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26615 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work for 26615 is less than key reference code 25607. Intuitively it would seem less difficult to fix a metacarpal than a phalanx and the 25th percentile work RVU would keep this rank order. The first postoperative visit would include a dressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings. The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, OT Rx for range of motion

exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 66% No 33%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 14% no change 86%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26615

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		56.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26650 Tracking Number F26 Specialty Society Recommended RVU: **6.00**
Global Period: 090 RUC Recommended RVU: **6.00**

CPT Descriptor: Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old female who suffered a carpometacarpal fracture dislocation of the thumb requires a closed reduction and percutaneous fixation of a first CMC dislocation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: The fracture dislocation of the base of the first metacarpal is reduced under fluoroscopic control. Kirschner wires are then passed through the fracture fragments holding the reduction. Pin caps are applied to the Kirschner wires.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart

- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

Examine and talk with patient

- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	26650					
Sample Size:	225	**Resp N:** 37	**Response:** 16.4 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**3.00**	5.00	20.00
Survey RVW:		3.00	6.00	**6.00**	7.00	9.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		10.00	20.00	**30.00**	30.00	60.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26650		
		Specialty Recommended
Physician Work RVU:		**6.00**
Pre-Service Evaluation Time:		**30.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**10.0**
Intra-Service Time:		**30.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25651	090	5.08	**RUC Time**

CPT Descriptor Percutaneous skeletal fixation of ulnar styloid fracture

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99291	XXX	3,260,677	4.50	**RUC Time**

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
11646	010	10,371	6.21	**RUC Time**

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 37.8 %

TIME ESTIMATES (Median)

	CPT Code: 26650	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	50.00	50.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**197.00**	**190.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.29	2.27
Urgency of medical decision making	2.14	2.18

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.18
Physical effort required	2.57	3.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.43	2.64
Outcome depends on the skill and judgment of physician	2.43	2.55
Estimated risk of malpractice suit with poor outcome	2.21	2.64

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.07	2.27
Intra-Service intensity/complexity	1.93	2.09
Post-Service intensity/complexity	2.79	2.64

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

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Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

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In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26650, we recommend 6.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26650 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

ɔtal work for 26650 is slightly greater than key reference code 25651. The first postoperative visit would include a ɹressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings. The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, removal of pin(s), OT Rx for range of motion exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 57% No 43%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 14% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26650

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		51.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 4.5	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26665 Tracking Number F27 Specialty Society Recommended RVU: **9.00**
Global Period: 090 RUC Recommended RVU: **9.00**

CPT Descriptor: Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old female who suffered a carpometacarpal fracture dislocation of the thumb requires an open reduction and internal fixation of a first CMC dislocation.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the radial volar aspect of first CMC joint. The branches of the superficial branch of the radial nerve are carefully protected. The extensor tendons are carefully retracted. The fracture is identified and cleared of any fibrinous material or clot. The fracture is reduced and provisionally held with small Kirschner wires. The fracture is then definitively fixed using small screws using a lag technique. The thenar musculature and fascia are then repaired. The subcutaneous and skin are closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	26665				
Sample Size: 225	**Resp N:** 37	**Response:** 16.4 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**3.00**	5.00	10.00
Survey RVW:	5.00	8.00	**9.00**	10.00	12.00
Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	30.00	45.00	**60.00**	60.00	105.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26665						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25652	090	7.92	RUC Time

CPT Descriptor Open treatment of ulnar styloid fracture

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	76,932	8.44	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50590	090	52,156	9.64	RUC Time

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 35.1 %

TIME ESTIMATES (Median)

	CPT Code: 26665	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	60.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**237.00**	**225.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.77	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.92	3.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.77	3.80
Physical effort required	3.00	2.90

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.15	3.08
Outcome depends on the skill and judgment of physician	3.62	3.50
Estimated risk of malpractice suit with poor outcome	2.92	2.92

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.15	3.00
Intra-Service intensity/complexity	2.85	2.80
Post-Service intensity/complexity	3.31	3.20

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

  Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

  Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26665, we recommend 9.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26665 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The total work for 26665 is greater than the work for 25652 given the increased intensity of dealing with an intraarticular fracture. The first postoperative visit would include a dressing change, wound check, CMS check, application of a thumb spica splint or cast, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings. The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint

and X-rays. The third visit would include X-rays, range of motion exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree

B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change

C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26665

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		70.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26685 Tracking Number F28 Specialty Society Recommended RVU: **8.00**
Global Period: 090 RUC Recommended RVU: **8.00**

CPT Descriptor: Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male suffers a fifth carpometacarpal joint dislocation requiring an open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the dorsal aspect of the fifth carpometacarpal joint. Dissection is carried down to the joint taking care to protect any branches of the dorsal branch of the ulnar nerve. The extensor tendons are gently retracted out of the field and the fifth carpometacarpal joint capsule opened. Any intervening soft tissue is removed and the joint is reduced. The joint is held in a reduced position and held with a Kirschner wire. The capsule is then repaired. The wound is then closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	26685					
Sample Size:	225	**Resp N:** 37	**Response:** 16.4 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**3.00**	5.00	12.00
Survey RVW:		6.00	8.00	**8.00**	9.00	12.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		20.00	45.00	**60.00**	60.00	105.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				
olonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in following table, and tab through to the key reference service box.

CPT Code: 26685						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	____					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25652	090	7.92	RUC Time

CPT Descriptor Open treatment of ulnar styloid fracture

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	RUC Time

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	76,932	8.44	RUC Time

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 37.8 %

TIME ESTIMATES (Median)

	CPT Code: 26685	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	50.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**227.00**	**225.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.91
Urgency of medical decision making	2.71	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	3.71	4.00
Physical effort required	2.86	3.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.14	3.09
Outcome depends on the skill and judgment of physician	3.21	3.45
Estimated risk of malpractice suit with poor outcome	2.57	2.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.93	3.00
Intra-Service intensity/complexity	2.43	2.73
Post-Service intensity/complexity	3.14	3.00

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26685, we recommend 8.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26685 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The total work for 26685 is very similar to key reference code 25652. The first postoperative visit would include a dressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings are discussed. The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, removal of

pin(s), OT Rx for range of motion exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 51% No 49%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 11% I do not agree 89%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26685

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		62.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26715 Tracking Number F29 Specialty Society Recommended RVU: **7.95**
Global Period: 090 RUC Recommended RVU: **7.95**

CPT Descriptor: Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old female suffers a second metacarpophalangeal joint dislocation requiring an open reduction and internal fixation

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An oblique palmar incision is made over the metacarpal head. Careful dissection is carried out taking care to avoid the neurovascular structures. The A-1 pulley is released. The flexor tendon and lumbrical are gentle retracted and the volar plate is gently teased out of the joint. The joint is then reduced. The stability of the joint is verified. The skin is then approximated.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report

- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	26715				
Sample Size:	225	**Resp N:** 32	**Response:** 14.2 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**2.00**	3.00	20.00
Survey RVW:	4.80	6.48	**7.95**	9.00	11.00
Pre-Service Evaluation Time:			**38.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	15.00	30.00	**40.00**	60.00	100.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(3
99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26715		
		Specialty Recommended
Physician Work RVU:		7.95
Pre-Service Evaluation Time:		38.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		40.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25671	090	6.32	RUC Time

CPT Descriptor Percutaneous skeletal fixation of distal radioulnar dislocation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	RUC Time

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	76,932	8.44	RUC Time

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 21.8 %

TIME ESTIMATES (Median)

	CPT Code: 26715	Key Reference CPT Code: 25671	Source of Time RUC Time
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	40.00	45.00	
Median Immediate Post-service Time	20.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	7[illegible].00	
Prolonged Services Time	0.0	[illegible].00	
Median Total Time	**220.00**	**21[illegible].00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.50
Urgency of medical decision making	2.71	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	2.57	2.50
Physical effort required	2.71	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.43	2.50
Outcome depends on the skill and judgment of physician	2.43	2.50
Estimated risk of malpractice suit with poor outcome	1.86	2.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	2.50
Intra-Service intensity/complexity	1.86	2.00
Post-Service intensity/complexity	3.14	3.00

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

- ***Evidence that technology has changed physician work.***

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Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

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In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26715, we recommend 7.95 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26715 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Code 26715 is more complex than 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single and similar to 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed. The survey median correctly ranks this service relative to these similar procedures. The first postoperative visit would include a dressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings are discussed. The second visit would include

removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, removal of pin(s), OT Rx for range of motion exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 59% No 41%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 95%
B. Patients requiring this service are now:
   more complex (more work) 95% less complex (less work) 0% no change 5%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 11% no change 89%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26715

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		58.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26735 Tracking Number F30 Specialty Society Recommended RVU: **8.40**
Global Period: 090 RUC Recommended RVU: **8.40**

CPT Descriptor: Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male who suffered a fracture of the middle phalanx of the long finger requires open reduction and internal fixation of the middle phalanx.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the middle phalanx of the long finger. The extensor mechanism is incised and gently retracted. The periosteum is elevated. The fracture is identified and cleared of any fibrinous material and clot. The fracture is then reduced. A plate is put into position holding the fracture in the reduced position. It is held using plate holding clamps. The screw holes are drilled and the screws applied taking care to choose the appropriate length of screws so as to not impinge on the underlying flexor tendons. The periosteum is carefully repaired as is the extensor mechanism. The skin is closed

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members

- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and nsurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD				
`pecialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association				
CPT Code:	26735				
Sample Size: 225	**Resp N:** 33	**Response:** 14.6 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	6.00	**10.00**	15.00	40.00
Survey RVW:	6.32	8.40	**9.50**	10.75	15.00
Pre-Service Evaluation Time:			**40.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	25.00	45.00	**60.00**	60.00	120.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
'fice time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**			
rolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in following table, and tab through to the key reference service box.

CPT Code: 26735		
		Specialty Recommended
Physician Work RVU:		8.40
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	RUC Time

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	796,932	8.44	RUC Time

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 30.3 %

TIME ESTIMATES (Median)

	CPT Code: 26735	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**237.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.11	4.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.57
Urgency of medical decision making	3.89	3.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.22	3.86
Physical effort required	3.44	3.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.44	3.57
Outcome depends on the skill and judgment of physician	4.11	4.29
Estimated risk of malpractice suit with poor outcome	3.44	3.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	3.86
Intra-Service intensity/complexity	2.78	2.57
Post-Service intensity/complexity	3.11	3.14

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of tl RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can ~~also be~~ used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26735, we recommend 8.40 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26735 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work for 26735 is less than key reference code 25608 (RVW=10.86) and another reference code 25607 (RVW=9.35). The survey 25th percentile is less than both of these codes and relates correctly to RSL code 28750 Arthrodesis, great toe; metatarsophalangeal joint (RVW=8.37) and 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (RVW=8.44). The first postoperative visit would include a dressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for

finger and wrist ROM, discussion of restrictions and operative findings . The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, OT Rx for range of motion exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for exam 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 52% No 48%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 17% I do not agree 83%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 17% no change 78%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26735

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		59.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26746 Tracking Number F31 Specialty Society Recommended RVU: **11.10**
Global Period: 090 RUC Recommended RVU: **11.10**

CPT Descriptor: Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26-year-old male suffers an intraarticular fracture of the base of the middle phalanx requiring an open reduction and internal fixation of the intraarticular fracture of the base of the middle phalanx.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A curvilinear incision is made over the dorsal aspect of the proximal interphalangeal joint. The incision is carried down to the extensor mechanism. The interval between the lateral bands and the central slip is identified and incised. Care is taken not to detach the central slip from the base of the middle phalanx. The articular surface is examined. The fracture fragments are then reduced and held with a small bone holding tenaculum. Provisional fixation is achieved using small Kirschner wires. Small screws are then placed to hold the reduction using lag technique. The extensor mechanism is then repaired. The skin is closed.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members

- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, a insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	26746					
Sample Size:	225	**Resp N:** 32	**Response:** 14.2 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		2.00	3.00	**6.00**	11.00	30.00
Survey RVW:		8.00	10.73	**11.10**	14.00	16.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		45.00	64.00	**83.00**	90.00	150.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26746		
		Specialty Recommended
Physician Work RVU:		**11.10**
Pre-Service Evaluation Time:		**45.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**83.00**
Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**101.0**	99211x **0.0** 12x **2.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	**RUC Time**

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	**RUC Time**

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	**RUC Time**

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 40.6 %

TIME ESTIMATES (Median)	CPT Code: 26746	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	83.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	101.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**303.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.23	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	3.10
Urgency of medical decision making	3.77	3.36
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.23	3.91
Physical effort required	3.25	3.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.31	3.18
Outcome depends on the skill and judgment of physician	4.15	4.00
Estimated risk of malpractice suit with poor outcome	3.69	3.45

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.42	3.10
Intra-Service intensity/complexity	2.92	2.70
Post-Service intensity/complexity	4.00	3.70

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26746, we recommend 11.10 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26746 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

These fractures can be every bit as difficult treat as the key reference code – total work is very similar. At the first pc op visit the dressing and splint are removed, the wound is checked, the circulation, sensation and motor function ar checked, the wound is redressed, X-rays are reviewed, and referral to OT is completed. The second visit includes dressing removal, suture removal, OT progress check, OT prescription, X-ray check. The third and fourth visits include wound check, ROM check, X-ray, OT prescription and a discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 82% No 18%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 4% I do not agree 96%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 4% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 17% no change 74%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26746

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		53.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		83.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26765 Tracking Number F32 Specialty Society Recommended RVU: **6.60**
Global Period: 090 RUC Recommended RVU: **6.60**

CPT Descriptor: Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male who suffered a fracture of the distal phalanx of the long finger requires an open reduction and internal fixation of the distal phalanx.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatic drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A curvilinear incision is made over the distal interphalangeal joint and distal phalanx. Care is taken to protect the underlying extensor mechanism and nail organ. The periosteum is elevated. The fracture is identified and cleared of any fibrinous material and clot. The fracture is reduced. Two Kirschner wires are then drilled across the fracture site maintaining the alignment of the fracture. Care is taken to maintain the appropriate alignment of the fracture fragments. The periosteum is repaired as is the skin.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	26765					
Sample Size:	225	**Resp N:**	33	**Response:** 14.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	4.00	**6.00**	10.00	40.00
Survey RVW:		4.00	6.60	**7.75**	8.75	11.50
Pre-Service Evaluation Time:				**35.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		20.00	30.00	**45.00**	60.00	70.00
Immediate Post Service-Time:	**20.00**	—				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**				
olonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26765		
		Specialty Recommended
Physician Work RVU:		**6.60**
Pre-Service Evaluation Time:		**35.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**10.0**
Intra-Service Time:		**45.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25652	090	7.92	**RUC Time**

CPT Descriptor Open treatment of ulnar styloid fracture

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
11646	010	10,371	6.21	**RUC Time**

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	**RUC Time**

CPT Descriptor 2 Repair initial inguinal hernia, age 5 years or over; reducible

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 30.3 %

TIME ESTIMATES (Median)

	CPT Code: 26765	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	55.00	50.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**217.00**	**225.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	3.22
Urgency of medical decision making	2.90	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.90	2.89
Physical effort required	2.60	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.90	3.22
Outcome depends on the skill and judgment of physician	2.80	3.22
Estimated risk of malpractice suit with poor outcome	2.70	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.89
Intra-Service intensity/complexity	2.00	2.56
Post-Service intensity/complexity	3.10	3.22

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

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- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of tl RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26765, we recommend 6.60 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26765 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Code 26765 requires less total work and is less complex than key reference code 25652. The 25th percentile work RVU reflects this difference better than the survey median. The first postoperative visit would include a dressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings. The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, OT Rx for range of motion exercises, and

discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 55% No 45%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 17% I do not agree 83%
B. Patients requiring this service are now:
   more complex (more work) 89% less complex (less work) 0% no change 11%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 17% no change 83%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26765

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		41.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:26785 Tracking Number F33 Specialty Society Recommended RVU: **7.45**
Global Period: 090 RUC Recommended RVU: **7.45**

CPT Descriptor: Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male suffers a dislocation of the PIP joint requiring an open reduction and internal fixation of the PIP dislocation.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available – with special attention to plates and screws
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A curvilinear dorsal incision is made over the proximal interphalangeal joint. Dissection is carried down to the extensor mechanism. The interval between the lateral bands and the central slip is identified and incised. Any interposed soft tissue within the joint is removed. The joint is then reduced. A small Kirschner wire is passed across the joint to maintain the reduction. The extensor mechanism is repaired. The skin is closed.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing, reinforced with long arm splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Daniel J. Nagle, MD, FACS R. Dale Blasier, MD, FACS Richard Friedman, MD, FACS William Creevy, MD					
Specialty(s):	American Society for Surgery of the Hand American Academy of Orthopaedic Surgeons American Shoulder and Elbow Surgeons Orthopaedic Trauma Association					
CPT Code:	26785					
Sample Size:	250	**Resp N:**	33	**Response:** 0.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**3.00**	5.00	25.00
Survey RVW:		4.80	7.45	**8.89**	10.00	14.50
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		15.00	33.00	**45.00**	60.00	120.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 26785		
		Specialty Recommended
Physician Work RVU:		7.45
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		45.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25652	090	7.92	RUC Time

CPT Descriptor Open treatment of ulnar styloid fracture

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
11646	010	10,371	6.21	RUC Time

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105266	7.88	RUC Time

CPT Descriptor 2 Repair initial inguinal hernia, age 5 years or over; reducible

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 24.2 %

TIME ESTIMATES (Median)

	CPT Code: 26785	Key Reference CPT Code: 25652	Source of Time RUC Time
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**227.00**	**225.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.88	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.20
Urgency of medical decision making	2.50	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.88	2.83
Physical effort required	2.63	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.38	2.83
Outcome depends on the skill and judgment of physician	2.75	2.83
Estimated risk of malpractice suit with poor outcome	2.38	2.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.88	2.17
Intra-Service intensity/complexity	2.13	2.17
Post-Service intensity/complexity	3.75	3.33

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, t' treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 26785, we recommend 7.45 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 26785 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Total work for 26785 is similar to key reference code 25652. The first postoperative visit would include a dressing change, wound check, CMS check, application of a splint, X-rays, OT Rx for finger and wrist ROM, discussion of restrictions and operative findings . The second visit would include removal of the splint, wound check, CMS check, suture removal, reapplication of a new splint and X-rays. The third visit would include X-rays, removal of pin(s), OT Rx for

range of motion exercises, and discussion of limitations. The fourth visit would include X-rays, assessment of ROM, OT Rx for ROM and strengthening and discussion of limitations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

as the work of performing this service changed in the past 5 years? Yes 52% No 48%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%

B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change

C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 19% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26785

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

2005 UTIL	Surveyed or Reference	CPT	DESC	2007 RVW	SPEC REC	IWPUT	NOTES	RUC NEW	RUC NEW	Total Time	Hosp Vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP (992-) P-SD	32	31	38	POST-OFF (992-) 15	14	13	12	11
5,098,625	MPC	99203	Office or other o	1.34	1.34	0.057		1.34	0.057	29	0.0	0.0	4			20	5								
3,228,657	MPC	99204	Office or other o	2.30	2.30	0.065		2.30	0.065	45	0.0	0.0	5			30	10								
16,274	RSL	26600	Closed treatmen	2.48	2.48	0.024		2.48	0.024	93	0.0	4.0	7	2		15	5							4	
3,260,677	MPC	99291	Critical care, eva	4.50	4.50	0.096		4.50	0.096	70	0.0	0.0	15			40	15								
107,426	MPC	64721	Neuroplasty and	4.84	4.84	0.024		4.84	0.024	171	0.5	3.0	20	15	10	25	20			0.5			2	1	
74	RSL	25651	Percutaneous sk	5.68	5.68	0.040		5.68	0.040	190	0.5	4.0	50			30	20			0.5			1	3	
161	survey	26650	Percutaneous sk	5.80	6.00	0.040		6.00	0.040	197	0.5	4.0	30	10	10	30	20			0.5			2	2	
3,621	RSL	28288	Ostectomy, parti	5.81	5.81	0.035		5.81	0.035	169	0.0	5.0	20			30	20						4		1
51,489	RSL	20680	Removal of impl	5.90	5.90	0.056		5.90	0.056	181	0.5	2.0	35	15	15	50	15			0.5				2	
142	survey	28675	Open treatment	2.97	6.00	0.042		6.00	0.042	197	0.5	4.0	30	10	15	30	15			0.5			2	2	
280	survey	28525	Open treatment	3.37	6.00	0.035		6.00	0.035	207	0.5	4.0	35	10	15	30	20			0.5			2	2	
10,371	MPC	11646	Excision, malign	6.21	6.21	0.069		6.21	0.069	128	0.0	1.0	20	5	5	65	10						1		
84	RSL	25671	Percutaneous sk	6.32	6.32	0.038		6.32	0.038	210	0.5	4.0	50			45	25			0.5			1	3	
1,873	survey	26765	Open treatment	4.21	6.60	0.037		6.60	0.037	217	0.5	4.0	35	10	10	45	20			0.5			2	2	
NEW '07	RSL	25109	Excision of tend	6.81	6.81	0.063		6.81	0.063	191	0.5	3.0	25	10	15	40	20			0.5			2	1	
517	survey	26785	Open treatment	4.25	7.45	0.053		7.45	0.053	227	0.5	4.0	40	10	15	45	20			0.5			2	2	
21	RSL	24332	Tenolysis, tricep	7.77	7.77	0.051		7.77	0.051	230	0.5	4.0	50			60	30			0.5			1	3	
105,266	MPC	49505	Repair initial ing	7.88	7.88	0.065		7.88	0.065	198	0.5	2.0	20	15	15	70	20			0.5			1	1	
152	RSL	25652	Open treatment	7.92	7.92	0.056		7.92	0.056	225	0.5	4.0	50			60	25			0.5			1	3	
249	survey	26715	Open treatment	5.79	7.95	0.073		7.95	0.073	220	0.5	4.0	38	10	15	40	20			0.5			2	2	
1,343	survey	26615	Open treatment	5.38	8.00	0.069		8.00	0.069	217	0.5	4.0	35	10	10	45	20			0.5			2	2	
1,001	survey	28645	Open treatment	4.27	8.00	0.070		8.00	0.070	217	0.5	4.0	35	10	15	45	15			0.5			2	2	
57	survey	26685	Open treatment	7.09	8.00	0.053		8.00	0.053	227	0.5	4.0	30	10	10	60	20			0.5			2	2	
448	survey	28505	Open treatment	3.86		0.072				227	0.5	4.0	40	10	15	45	20			0.5			2	2	
1,963	survey	28485	Open treatment	5.77	8.00	0.049		8.00	0.049	242	0.5	4.0	40	10	15	60	20			0.5			2	2	
2,885	RSL	28289	Hallux rigidus co	8.11	8.11	0.069		8.11	0.069	197	0.0	4.0	30			45	30						4		
15,070	MPC	43269	Endoscopic retro	8.20	8.20	0.093		8.20	0.093	141	0.0	0.0	40			71	30								
4,575	RSL	28750	Arthrodesis, gre	8.37	8.37	0.042		8.37	0.042	237	0.0	4.0	40			75	30						4		
1,692	survey	26735	Open treatment	6.03	8.40	0.056		8.40	0.056	237	0.5	4.0	40	10	10	60	20			0.5			2	2	
76,932	MPC	14040	Adjacent tissue	8.44	8.44	0.050		8.44	0.050	223	0.0	4.0	15	10	5	90	25						2	2	
1,547	survey	27766	Open treatment	8.73	8.50	0.045		8.50	0.045	266	2.0	4.0	40	10	15	45	20		1	1.0			2	2	
13,149	RSL	28292	Correction, hallu	8.72	8.72	0.042		8.72	0.042	245	1.0	4.0	30			60	25			1.0			4		
32,582	RSL	29824	Arthroscopy, sho	8.82	8.82	0.065		8.82	0.065	225	0.5	4.0	48			60	20			0.5			2	2	
85	survey	26665	Open treatment	7.72	9.00	0.067		9.00	0.067	237	0.5	4.0	35	10	15	60	20			0.5			2	2	
1,260	survey	25545	Open treatment	9.09	9.00	0.039		9.00	0.039	286	2.0	4.0	40	10	10	60	30		1	1.0			2	2	
91,000	MPC	14060	Adjacent tissue	9.07	9.07	0.090		9.07	0.090	183	0.0	4.0	15	10	5	60	15						2	2	
NEW '07	RSL	25607	Open treatment	9.35	9.35	0.052		9.35	0.052	275	0.5	5.0	40	10	15	60	30			0.5			3	2	
6,720	survey	24685	Open treatment	8.92	9.50	0.069		9.50	0.069	252	0.5	4.0	40	15	10	60	30			0.5			2	2	
209	survey	28465	Open treatment	7.13		0.085				257	0.5	4.0	45	10	15	60	30			0.5			2	2	
2,218	survey	27829	Open treatment	5.68	9.50	0.096	Survey da	9.50		271	2.0	4.0	45	10	15	45	20						2	2	
52,156	MPC	50590	Lithotripsy, extra	9.64	9.64	0.080		9.64	0.080	234	0.5	3.0	35	15	13	60	30			0.5			2	1	
4,368	RSL	25115	Radical excision	9.89	9.89	0.050		9.89	0.050	257	0.0	4.0	45			90	30						4		
661	survey	25515	Open treatment	9.37	10.00	0.079		10.00	0.079	247	0.5	4.0	40	10	10	60	30			0.5			2	2	
676	survey	24635	Open treatment	13.56	10.00	0.055		10.00	0.055	291	2.0	4.0	40	10	15	60	30		1	1.0			2	2	
370	survey	25574	Open treatment	7.47	10.00	0.053		10.00	0.053	296	2.0	4.0	45	10	15	60	30		1	1.0			2	2	
2,230,788	MPC	66984	Extracapsular ca	10.36	10.36	0.211		10.36	0.211	162	0.5	4.0	10	5	10	30	10			0.5			2	2	
146	survey	28555	Open treatment	6.42	10.43	0.066	The numb	10.43		281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
316	survey	27784	Open treatment	7.41	10.45	0.066		10.45	0.066	281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
5,492	survey	27792	Open treatment	7.91	10.50	0.067		10.50	0.067	281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
NEW '07	RSL	25608	Open treatment	10.86	10.86	0.052		10.86	0.052	305	0.5	5.0	40	10	15	90	30			0.5			3	2	
268	survey	25628	Open treatment	9.50	11.00	0.065		11.00	0.065	277	0.5	4.0	45	10	15	90	20			0.5			2	2	
660	survey	23515	Open treatment	7.47	11.00	0.062		11.00	0.062	287	0.5	4.0	40	15	15	90	30			0.5			2	2	
9	survey	27832	Open treatment	6.87	11.00	0.059		11.00	0.059	301	2.0	4.0	45	10	15	75	20		1	1.0			2	2	
195	survey	24575	Open treatment	11.02	11.00	0.060		11.00	0.060	308	2.0	4.0	45	15	15	60	30		1	1.0			3	1	

UTIL	Surveyed or Reference	CPT	DESC	2007 RVW	SPEC REC	IWPUT	NOTES	RUC NEW	RUC NEW	Total Time	Hosp Vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP (992-) P-SD	32	31	38	POST-OFF (992-) 15	14	13	12	11
933	survey	26746	Open treatment	5.86	11.10	0.058		[redacted]	0.058	303	0.5	5.0	45	10	15	83	30			0.5			3	2	
3,398	MPC	28299	Correction, hallu	11.39	11.39	0.058		11.39	0.058	299	0.5	4.0	75			90	30			0.5			3	1	
873	survey	28615	Open treatment	8.96	11.50	0.056	The numb	[redacted]		323	2.0	6.0		10		60	18		1	1.0				3	
13,957	survey	27814	Open treatment	11.10		0.075				346	2.0	4.0	45	10	15	90	30	1		1.0			2	2	
239	survey	25525	Open treatment	12.69	12.00	0.064	The numb	[redacted]		303	2.0	4.0	45	10	15	70	20		1	1.0				1	
971	survey	23630	Open treatment	7.47	12.00	0.070		[redacted]	0.070	306	2.0	4.0	43	15	15	70	20		1	1.0			3	1	
203	survey	28585	Open treatment	8.17	12.00	0.053	The numb	[redacted]		324	2.0	5.0	45	10	15	75	20		1	1.0				2	
208	survey	27826	Open treatment	8.97		0.091	The numb			328	2.0	4.0	45	15	15	60	30	1		1.0				1	
10,859	MPC	60220	Total thyroid lob	12.29	12.29	0.077		12.29	0.077	275	2.0	2.0	63			90	25		1	1.0			1	1	
152	RSL	28261	Capsulotomy, m	12.91	12.91	0.050		12.91	0.050	343	2.0	4.0	60			103	30		1	1.0			4		
636	survey	24579	Open treatment	11.96	13.00	0.062		[redacted]	0.062	338	2.0	4.0	45	15	15	90	30		1	1.0			3	1	
239	survey	23670	Open treatment	8.02	14.00	0.080		[redacted]	0.080	326	2.0	4.0	40	15	15	90	30		1	1.0			2	2	
7,914	survey	23615	Open treatment	10.93		0.085				338	2.0	4.0	45	15	15	90	30		1	1.0			3	1	
1,337	survey	25575	Open treatment	12.02	14.00	0.059	The numb	[redacted]		342	2.0	5.0	45	10	15	90	30		1	1.0					
NEW '07	RSL	25609	Open treatment	14.12	14.12	0.058		14.12	0.058	358	0.5	6.0	40	10	15	120	30			0.5			4	2	
7,278	survey	27822	Open treatment		14.75	0.076			0.047	353	2.0	4.0	45	10	15	90	30	1		1.0			3	1	
25,915	RSL	23420	Reconstruction c	14.75	14.75	0.054		14.75	0.054	368	2.0	5.0	45			120	30		1	1.0			5		
197	survey	23680	Open treatment	10.30	15.00	0.067		[redacted]	0.067	361	2.0	4.0	45	15	15	120	30		1	1.0			2	2	
1,426	survey	24545	Open treatment	10.88	15.00	0.067		[redacted]	0.067	361	2.0	4.0	40	20	15	120	30		1	1.0			2	2	
1,384	survey	27823	Open treatment			0.072			0.064	366	2.0	4.0	45	15	15	98	30	1		1.0			3	1	
130	survey	25526	Open treatment	13.43	15.00	0.055	The numb	[redacted]		367	2.0	5.0	45	10	15	115	30		1	1.0					
31,681	RSL	29827	Arthroscopy, sho	15.44	15.44	0.083		15.44	0.083	334	0.5	5.0	75			120	40			0.5				5	
863	survey	27827	Open treatment	15.75		0.080	The numb			441	3.0	5.0	55	15	15	120	30	1	1	1.0				1	
355	survey	23585	Open treatment	9.15	16.25	0.067		[redacted]	0.067	407	3.0	4.0	60	23	15	120	33		2	1.0			2	2	
1,163	MPC	65750	Keratoplasty (co	16.60	16.60	0.108		16.60	0.108	288	0.0	6.0	40			90	20						6		
1,331	survey	24546	Open treatment	15.99		0.083	The numb			448	3.0	4.0	50	20	15	150	30	1	1	1.0				1	
33,064	MPC	58150	Total abdominal	17.21	17.21	0.071		17.21	0.071	394	5.0	2.0	45	5	10	120	30	1	3	1.0			2		
218	RSL	27709	Osteotomy; tibia	17.32	17.32	0.093		17.32	0.093	347	3.0	4.0	40	18	10	108	15		2	1.0			2	2	
101,683	RSL	27236	Open treatment	17.43	17.43	0.060		17.43	0.060	473	6.0	4.0	60	15	15	90	30	2	3	1.0			3	1	
999	survey	28415	Open treatment	17.54		0.080	The numb			441	3.0	5.0	55	15	15	120	30	1	1	1.0				1	
55	survey	28420	Open treatment	17.07		0.086	The numb			481	3.0	5.0	60	20	15	150	30	1	1	1.0				1	
6,992	MPC	37215	Transcatheter pl	19.58	19.58	0.122		19.58	0.122	347	2.0	2.0	60	15	15	103	30	1		1.0			2		
1,118	survey	27828	Open treatment	18.19		0.091	The numb			471	3.0	5.0	55	15	15	150	30	1	1	1.0				1	
412	RSL	28705	Arthrodesis; par	20.12	20.12	0.058		20.12	0.058	490	3.0	4.0	75			180	35	1	1	1.0		1	2	1	
4,678	survey	23616	Open treatment	21.68	21.00	0.097	The numb	[redacted]		413	3.0	4.0	60	15	15	120	30	1	1	1.0				1	
370	survey	28445	Open treatment			0.092			0.059	444	3.0	5.0	58	15	15	120	30	1	1	1.0				1	
2,260	MPC	50546	Laparoscopy, su	21.69	21.69	0.064		21.69	0.064	467	4.0	3.0	60			205	18		3	1.0		1	2		
16,470	RSL	23472	Arthroplasty, gle	22.47	22.47	0.079		22.47	0.079	458	4.0	4.0	60			165	30	1	2	1.0			3	1	
382,332	RSL	27447	Arthroplasty, kne	23.04	23.04	0.099		23.04	0.099	469	5.0	4.0	45	15	15	124	30	1	3	1.0		1	2	1	
996	MPC	63051	Laminoplasty, ce	25.38	25.38	0.086		25.38	0.086	495	4.0	3.0	55	25	15	190	30	1	2	1.0			2	1	
11,399	MPC	44204	Laparoscopy, su	26.29	26.29	0.097		26.29	0.097	455	5.0	3.0	45			180	30	1	3	1.0			2	1	
18,866	RSL	27487	Revision of total	26.91	26.91	0.081		26.91	0.081	520	6.0	4.0	60			200	30		5	1.0			4		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Femoral Head Fracture Treatment

when

The CPT Editorial Panel created three new Category I CPT codes to describe services performed by orthopedists that are distinctly different from the treatment of other proximal femoral fractures, involving the femoral neck, intertrochanteric or subtrochanteric regions. Whereas these other fractures do not involve the femoral head (i.e. the cartilage covered "ball" of the hip joint's "ball joint articulation") fractures of the femoral head are both intraarticular and intracapsular by definition. These injuries may involve any part of the femoral head. Displaced fractures, especially those involving the superior head, place the hip joint at grave risk for developing osteoarthritis (degeneration of the joint) as the weight bearing portion is affected directly. New codes are necessary to reflect the management of these patients and the varied injury patterns that have been described. An open treatment code is required as the procedure is distinctly different from the treatment of other proximal femoral fractures as fractures of the head usually require a hip arthrotomy with a surgical dislocation of the hip to affect a repair and place internal fixation.

The specialty societies surveying CPT codes 27267, *Closed treatment of femoral fracture, proximal end, head; without manipulation*; 27268, *Closed treatment of femoral fracture, proximal end, head; with manipulation*; and 27269, *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed,* commented and the RUC agreed that the vignettes were confusing and required further refinement by the CPT Editorial Panel. The survey respondents indicated they were unable to determine what if any work was involved in the procedure and the survey results were problematic in that most respondents were unable to identify any time in the pre-, intra- or post-service procedures because they agreed, that the vignette was potentially flawed. The RUC decided to refer the codes to the Editorial Panel for refinement of the vignettes and request that once the revised vignettes are finalized that the specialty societies re-survey the services for review by the RUC at the September 2007 RUC meeting. **In the interim, the RUC agreed that it was appropriate for the services to be carrier priced.**

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●27267	W1	Closed treatment of femoral fracture, proximal end, head; without manipulation	090	Carrier Priced (Interim)
●27268	W2	with manipulation	090	Carrier Priced (Interim)
●27269	W3	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed (Do not report 27269 in conjunction with 27033, 27253)	090	Carrier Priced (Interim)

518

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Internal or External Fixation-Hip and Knee

As part of the 2005 Five-Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2006 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty society that these codes needed to be clarified and reference to external fixation should be removed from 64 CPT codes. These 64 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. These recommendations specifically detail the RUC's recommendations for the Hip/Knee codes as discussed at the April 2007 RUC Meeting.

Approximately 150 orthopaedic providers participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, orthopaedic trauma surgery and hip and knee surgery. After the results from all of these groups were tabulated, a consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons and Orthopaedic Trauma Association met to discuss the survey data for the revised orthopaedic codes.

The RUC reviewed the compelling evidence for these procedures. The specialty societies claimed that because the CPT descriptors originally contained the phrase "with or without internal or external fixation," it is difficult to imagine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC

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and CMS and others were adjusted up or down but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs.

Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. The specialty societies conducted a full RUC survey of all codes, and for over half of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending the current work RVUs for two codes of the codes in this family, 27519 and 27540.

The RUC thoroughly reviewed these codes, and as part of this review, the specialty societies explained that they felt strongly that a 99233 hospital visit was appropriate for all of the codes within this family however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialty societies explained that they felt strongly that three 99213 office visits were appropriate for all of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC also reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)*. It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC determined that there will be no work neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

27248 *Open treatment of greater trochanteric fracture, includes internal fixation, when performed*

The RUC reviewed CPT code 27248 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however,

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based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is significantly greater than the surveyed code, 90 minutes and 60 minutes respectively. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater mental effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC agreed that because of the greater amount of time and the greater mental effort and judgment associated with the reference code in comparison to the surveyed code, the RUC recommends the 25th percentile of the survey data minus the work RVU associated with the amended post-operative visits, 12.83 RVUs for 27248. **The RUC recommends 12.83 work RVUs for 27248.**

27511 *Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed*

The RUC reviewed CPT code 27511 and compared it with 27477 *Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal* (work RVU=23.04). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is slightly greater than the surveyed code, 124 minutes and 120 minutes respectively. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater physical effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC agreed that because of the greater amount of time and the greater physical effort and overall higher intensity to perform associated with the reference code in comparison to the surveyed code, the RUC recommends the 25th percentile of the survey data, 18.05 RVUs for 27511. **The RUC recommends 18.05 work RVUs for 27511.**

27513 *Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed*

The RUC reviewed CPT code 27513 and compared it with 27477 *Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal* (work RVU=23.04). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on

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discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total service time for the reference code and the surveyed code is very similar, 469 minutes and 464 minutes respectively. Furthermore, the RUC agreed with the specialty that although when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and judgment and more overall intensity to perform than the reference code that both procedures have similar intensity. Therefore, the RUC agreed that because of the similar amount of total service time and similar intensities between the reference code and the surveyed code, that these two codes should be valued the same, 23.04 RVUs. **The RUC recommends the median of the survey data, 23.04 work RVUs for 27513.**

27514 *Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed*

The RUC reviewed CPT code 27514 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code and the surveyed code were the same, 90 minutes. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires similar overall intensity to perform as compared to the surveyed code. Therefore, the RUC agreed that because of the same amount of intra-service time and overall similar intensity to perform the surveyed code should be valued the same as the reference code, 17.43 RVUs. **The RUC recommends the 25th percentile of the survey data, 17.43 work RVUs for 27514.**

27519 *Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed*

The RUC reviewed CPT code 27519 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this

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procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total-service time for the reference code is significantly greater than the surveyed code, 473 minutes and 359 minutes respectively. However, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and judgment and more overall intensity to perform than the reference code. Therefore, the specialty society recommended that the current value be maintained for this code as the current value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27236. The RUC agreed with the specialty society and recommends that the surveyed times and visits be applied to this code and its current value should be maintained. **The RUC recommends maintaining the current value of 15.80 work RVUs for 27519.**

27535 *Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed*

The RUC reviewed CPT code 27535 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total service time for the reference code is significantly greater than the surveyed code, 473 minutes and 389 minutes. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater overall intensity to perform as compared to the surveyed code. Therefore, the RUC agreed that because of the greater amount of total service time and the higher amount of overall intensity to perform of the reference code as compared to the surveyed code, the surveyed code should be valued at the surveyed 25th percentile, 16.00 RVUs. **The RUC recommends 16.00 work RVUs for 27535.**

27540 *Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed*

The RUC reviewed CPT code 27540 and compared it with 29833 *Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)* (work RVU=11.61). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although

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the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total-service time for the surveyed code is significantly greater than the reference code, 334 minutes and 311 minutes respectively. Further, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and judgment and more overall intensity to perform than the reference code. The specialty society recommended that the surveyed code should be valued higher than the reference code based on these survey results but believed that the 25th percentile and median RVU value of the survey data both over-estimated the value of this procedure and would create rank-order anomalies with the other knee and hip fracture codes. The RUC agreed with the specialty society and recommends that the surveyed times and visits be applied to this code and its current value should be maintained. **The RUC recommends maintaining the current value of 13.45 work RVUs for 27540.**

27556 *Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction*

The RUC reviewed CPT code 27556 and compared it with 27415 *Osteochondral allograft, knee, open* (work RVU=19.79). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is significantly greater than the surveyed code, 120 minutes and 90 minutes respectively. Further, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater mental effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC recommends the 25th percentile of the RVU value of the survey data or 15.50 RVU for 27556. This value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27415. **The RUC recommends 15.50 work RVUs for 27556.**

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27557 *Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair*

The RUC reviewed CPT code 27557 and compared it with 27415 *Osteochondral allograft, knee, open* (work RVU=19.79). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total-service time for the reference code is significantly greater than the surveyed code, 424 minutes and 399 minutes respectively. However, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and psychological judgment and more overall intensity to perform than the reference code. Therefore, the specialty society recommended that the 25th percentile of the work RVU of the survey data for this code, 19.00 RVUs. This value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27415. The RUC agreed with the specialty society and recommends that the surveyed times and visits be applied to this code and the current value should be 19.00 RVUs. **The RUC recommends 19.00 work RVUs for 27557.**

27558 *Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction*

The RUC reviewed CPT code 27558 and compared it with 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU=30.13). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is significantly greater than the surveyed code, 240 minutes and 150 minutes respectively. Further, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater mental effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC recommends the 25th percentile of the RVU value of the survey data or 22.00 RVU for 27558. This value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27134. **The RUC recommends 22.00 work RVUs for 27558.**

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Practice Expense:
The RUC recommends the standard 090 day global practice expense packages. The only exceptions to the standard 090 day global practice expense packages was where the procedure was considered to be emergent and the pre-service time allocated in the facility setting was removed.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Musculoskeletal System Pelvis and Hip				
▲27248	F34	Open treatment of greater trochanteric fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	12.83
Surgery Musculoskeletal System Femur and Knee				
▲27511	F35	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	18.05
▲27513	F36	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	23.04
▲27514	F37	Open treatment of femoral fracture, distal end, medial or lateral condyle, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	17.43
▲27519	F38	Open treatment of distal femoral epiphyseal separation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	15.80 (No Change)
▲27535	F39	Open treatment of tibial fracture, proximal (plateau); unicondylar, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	16.00

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▲27540	F40	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	13.45 (No Change)
▲27556	F41	Open treatment of knee dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed; without primary ligamentous repair or augmentation/reconstruction	090	15.50
▲27557	F42	with primary ligamentous repair	090	19.00
▲27558	F43	with primary ligamentous repair, with augmentation/reconstruction	090	22.00

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27248 Tracking Number F34 Specialty Society Recommended RVU: **12.83**
Global Period: 090 RUC Recommended RVU: **12.83**

CPT Descriptor: Open treatment of greater trochanteric fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female falls two years after successful total hip arthroplasty sustaining a displaced fracture of the greater trochanter of the hip requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning in a lateral position, held by a lateral positioning device; padding of bor prominences, with care taken to protect the axillary region as well as the downside peroneal nerve; and application thermal regulation drapes
- Assess position of the extremities and head, adjust as needed

Confirm ability to visualize operative area with fluoroscopy
- Indicate areas of skin to be prepped and mark surgical incisions
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, a lateral incision is made over the greater trochanter. A dissection is carried down to the fascia lata which is split longitudinally. The fracture fragments are identified. A portion of the vastus lateralis is elevated in order to anatomically reduce the fracture site. A combination of wires or cables are passed around the medial side of the femoral shaft. The wires or cables require a careful dissection along the posterior aspect of the femur in order to pass them safely - positioning is checked under fluoroscopy. A combination of wires or cables, screws and potentially a trochanteric grip are placed about the greater trochanter and used to reduce the fracture of the greater trochanter. The position of the fixation and the reduction is checked either with a fluoroscopy or plain film. The wound is closed in layers over drains, closing the fascia lata, subcutaneous tissues and then reapproximating the skin edges..

Description of Post-Service Work: Post-service work: in facility
- Application of dressing and abduction splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor – followed by daily monitoring of the wound, drains, anticoagulation, and physical therapy.

- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments
- Dictation of an operative report
- Procedure note is written in the patient chart

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of dressings
- Assessment of surgical wound
- Remove sutures and drains
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

URVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association					
CPT Code:	27248					
Sample Size:	150	**Resp N:** 43	**Response:** 28.6 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**1.00**	2.00	6.00
Survey RVW:		6.00	14.38	**16.00**	18.00	25.00
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**20.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		45.00	60.00	**60.00**	90.00	180.00
Immediate Post Service-Time:	**20.00**					
st Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
tical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**115.0**	99231x **1.0** 99232x **1.0** 99233x **1.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				

Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27248		
		Specialty Recommended
Physician Work RVU:		12.83
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		20.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	100.0	99231x 1.0 99232x 2.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 48.8 %

TIME ESTIMATES (Median)

	CPT Code: 27248	Key Reference CPT Code: 27236	Source of Time RUC Time
Median Pre-Service Time	95.00	90.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**384.00**	**473.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.48	2.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.95
Urgency of medical decision making	2.90	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	3.11
Physical effort required	3.42	3.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.48	3.58
Outcome depends on the skill and judgment of physician	3.81	3.68
Estimated risk of malpractice suit with poor outcome	2.90	2.84

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.90	3.00
Intra-Service intensity/complexity	3.14	3.17
Post-Service intensity/complexity	2.90	2.94

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, especially with respect to the primary provider subspecialty - trauma, since the AMA Masterfile did not delineate orthopaedic subspecialties. This may have led to an underestimation of post-service work in the Harvard survey.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with tl reference code and other orthopaedic services.

We are recommending a work RVU of 14.38 which is the 25% survey result with a IWPUT of .060 which is the same as the IWPUT for 27236, our key reference service. Our key comparison service was 27236, with a work RVU of 17.36, intra-service time of 90 minutes, four total post-operative hospital visit days plus one discharge day, and four

total post-operative office visit days with 3 99213's and 1 99212. The total time for our comparison code 27236 is 473. We felt the survey median RVU for 27248 of 16.00 was slightly higher than the procedure warrants. The 14.38 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27236, which has a RUC validated work RVU of 17.43 but has more intra-service time (appropriate because 27248 does not take quite as long) and 27236 also has more post operative hospital visits than the surveyed code, 27248. The pre-service time for 27248 is 20 minutes for evaluation time, 20 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27248 is 60 minutes, which we believe is appropriate. The survey immediate post service time was 30 minutes, which again we believe to be appropriate. We are recommending three total hospital visits, 1-99233, 1-99232 and 1-99231 plus one discharge day, 99238. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes, as well as being the same office visit package as the comparison code 23236.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 28% No 72%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 25% I do not agree 75%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 8% no change 92%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27511 Tracking Number F35 Specialty Society Recommended RVU: **18.05**
Global Period: 090 RUC Recommended RVU: **18.05**

CPT Descriptor: Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male sustains a supracondylar femur fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
-
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: The leg is elevated and exsanguinated; the pneumatic tourniquet is inflated. An incision is made over the lateral side of the leg extending from the articular surface approximately 15 cm proximal to the knee. The dissection is carried down to the fascia lata which is split. Subsequently, the vastus lateralis posterior edge is identified. Careful dissection is performed along the posterior aspect of this as the femoral shaft is approached. All of the perforating branches from the profunda femoris artery are identified and electrocauterized or ligated. The fracture site is identified. The fracture hematoma is cleaned out. A provisional reduction is achieved by longitudinal traction of the leg. This may require use of a femoral distractor. A locking type plate is applied to the lateral cortex. Screws are placed into the femoral condyle with their length checked and confirmed fluoroscopically. Then screws are placed into the proximal portion of the femur in a similar manner. The quality of the reduction in the AP and lateral radiographs is checked either with a fluoroscopic unit or with permanent radiographs. Subsequently, all of the screws are checked and tensioned again, and additional screws are added. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the layers are closed sequentially beginning with the vastus lateralis, then the fascia lata, the subcutaneo tissues and then the skin. .

Description of Post-Service Work: Post-service work: in facility
- Application of dressing and brace.
- Monitor patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.

'he limb is positioned in a CPM device.

- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Dictation of an operative report

- Procedure note is written in the patient chart

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound

Order occupational therapy

Supervision of rehabilitation

- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association					
CPT Code:	27511					
Sample Size:	150	**Resp N:**	42	**Response:** 28.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**5.00**	6.00	50.00
Survey RVW:		12.50	18.05	**20.96**	23.04	30.00
Pre-Service Evaluation Time:				**60.0**		
e-Service Positioning Time:				**15.0**		
re-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	76.00	**120.00**	120.00	180.00
Immediate Post Service-Time:	**20.00**					

CPT Code: 27511

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	115.0	99231x **1.0** 99232x **1.0** 99233x **1.0**
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**
Office time/visit(s):	85.0	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27511		
		Specialty Recommended
Physician Work RVU:		**19.41**
Pre-Service Evaluation Time:		**60.0**
Pre-Service Positioning Time:		**15.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**120.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**100.0**	99231x **1.0** 99232x **2.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27477	090	23.04	**RUC Time**

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 30.9 %

TIME ESTIMATES (Median)

	CPT Code: 27511	Key Reference CPT Code: 27477	Source of Time RUC Time
Median Pre-Service Time	90.00	75.00	
Median Intra-Service Time	120.00	124.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**439.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	3.45
Urgency of medical decision making	3.62	2.45

Technical Skill/Physical Effort (Mean)

Technical skill required	4.08	3.91
Physical effort required	3.69	3.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.85	4.09
Outcome depends on the skill and judgment of physician	4.08	3.91
Estimated risk of malpractice suit with poor outcome	3.77	3.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.54	3.55
Intra-Service intensity/complexity	3.45	3.55
Post-Service intensity/complexity	2.45	3.18

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

  This code was never surveyed by Harvard. The current RVW is based on an Abt study that did not collect time and visit information, but "relative" RVW based on an algorithm.

  Given this information, we believe there is compelling evidence that the current value may be flawed and without evidence.

- ***Evidence that technology has changed physician work.***

  Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

  Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics. arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

We are recommending a work RVU of 20.96 which is the median survey result. Our key comparison service was 27447, with a work RVU of 23.04, intra-service time of 124 minutes, four total post-operative hospital visit days plus one discharge day, and four total post-operative office visit days with 1-99214, 2-99213 and 1- 99212. The total time for our comparison code 27447 is 469. We felt the survey median RVU for 27511 of 20.96 is appropriate for the service and maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27447, which has a RUC validated work RVU of 23.04 but has more intra-service time and more post operative hospital and office visits than the surveyed code, 27511. The pre-service time for 27511 is 15 minutes for evaluation

time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27511 is 120 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending three total hospital visits, 1-99233, 1-99232 and 1-99231 plus one discharge day, 99238 which is consistent with the other Hip and Knee Fracture codes in this family. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for those Hip and Knee Fracture codes that are similar in work, and maintains relativity with the reference code, 27447 which has one more post-operative office visit at a higher level. The IWPUT for 27511 is .088 which we believe is appropriate for a service of this complexity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 40% No 60%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 24% I do not agree 76%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 8% no change 92%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27513 Tracking Number F36 Specialty Society Recommended RVU: **23.04**
Global Period: 090 RUC Recommended RVU: **23.04**

CPT Descriptor: Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male sustains a supracondylar femur fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: The leg is elevated and exsanguinated; the pneumatic tourniquet is inflated. A midline or lateral incision is made and an arthrotomy is performed. A careful dissection occurs into the knee joint. The articular fragments will be carefully preserved. The fracture fragments are all identified and an attempt is made to achieve an anatomic reduction of the articular surface. This may require several attempts at reduction and passage of K-wires for provisional fixation and then placement of lag compression screws. These are carefully placed either very anteriorly or very posteriorly in order to allow fixation of the distal femur to the more proximal femur. The quality of this reduction is checked under fluoroscopic or radiographic guidance. Further fixation of the condyles of the femur to the femoral shaft is performed either with an intramedullary rod which is passed through the intercondylar notch up into the proximal aspect of the femur with locking screws being placed through the femoral condyles and through the more proximal femur or a lateral plate is used, requiring additional screws placed through a separate incision. The lag screws distally are checked for position fluoroscopically. The quality of the reduction and the position of the implants is confirmed with radiographs or fluoroscopy. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the wound is closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Range of motion is checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee brace are applied.

The limb is positioned in a knee CPM machine.

- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

Dictation of an operative report

- Procedure note is written in the patient chart
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy

Supervision of rehabilitation

- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association					
CPT Code:	27513					
Sample Size:	150	**Resp N:**	43	**Response:** 28.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**6.00**	10.00	60.00
Survey RVW:		11.00	20.63	**23.04**	26.00	32.00
Pre-Service Evaluation Time:				**60.0**		
e-Service Positioning Time:				**15.0**		
re-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		70.00	120.00	**145.00**	180.00	240.00
Immediate Post Service-Time:	**20.00**					

CPT Code: 27513

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	115.0	99231x 1.0 99232x 1.0 99233x 1.0
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27513		
		Specialty Recommended
Physician Work RVU:		**23.04**
Pre-Service Evaluation Time:		**60.0**
Pre-Service Positioning Time:		**15.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**145.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**100.0**	99231x **1.0** 99232x **2.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27477	090	23.04	**RUC Time**

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 27.9 %

TIME ESTIMATES (Median)

	CPT Code: 27513	Key Reference CPT Code: 27477	Source of Time RUC Time
Median Pre-Service Time	90.00	75.00	
Median Intra-Service Time	145.00	124.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**464.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.60
Urgency of medical decision making	3.92	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.58	4.00
Physical effort required	4.17	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.92	3.60
Outcome depends on the skill and judgment of physician	4.25	3.80
Estimated risk of malpractice suit with poor outcome	3.33	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.08	3.80
Intra-Service intensity/complexity	4.33	4.00
Post-Service intensity/complexity	3.45	3.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

  This code was never surveyed by Harvard. The current RVW is based on an Abt study that did not collect time and visit information, but "relative" RVW based on an algorithm.

  Given this information, we believe there is compelling evidence that the current value may be flawed and without evidence.

- ***Evidence that technology has changed physician work.***

  Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

  Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.
We are recommending a work RVU of 23.04 which is the median survey result. Our key comparison service was 27447, with a work RVU of 23.04, intra-service time of 124 minutes, four total post-operative hospital visit days plus one discharge day, and four total post-operative office visit days with 1-99214, 2-99213 and 1- 99212. The total time for our comparison code 27447 is 469. We felt the survey median RVU for 27513 of 23.04 is appropriate for the servi and maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key referenc service, 27447, which has the same work RVU as we are recommending and we believe these two codes, while slightly different in terms of times, are collectively similar. 27447 has a RVU of 23.04 with less intra-service time and more post operative hospital and office visits than the surveyed code, 27513. The IWPUT for 27513 (.083) is lower than the IWPUT for 27447 which we believe is appropriate when comparing the levels of intensity. The pre-service time for

27513 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27513 is 145 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending three total hospital visits, 1-99233, 1-99232 and 1-99231 plus one discharge day, 99238 which is consistent with the hospital visits recommended or other Hip and Knee fracture codes. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for those Hip and Knee Fracture codes that are similar in work, and maintains relativity with the reference code, 27447 which has one more post-operative office visit at a higher level.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 51% No 49%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 36% I do not agree 64%
B. Patients requiring this service are now:
   more complex (more work) 82% less complex (less work) 0% no change 18%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 5% no change 95%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27514 Tracking Number F37 Specialty Society Recommended RVU: **17.43**
Global Period: 090 RUC Recommended RVU: **17.43**

CPT Descriptor: Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female trips and sustains a displaced fracture of the lateral femoral condyle requiring open reduction and internal fixation..

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulat. drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
-
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: The leg is elevated and exsanguinated; the pneumatic tourniquet is inflated. An incision is made over the lateral side of the limb extending from the articular surface approximately 15 cm from the knee. The dissection is carried down to the fascia lata which is split. Subsequently, the vastus lateralis posterior edge is identified. Careful dissection is performed along the posterior aspect of this as the femoral shaft is approached. All of the perforating vessels from the profunda femoris artery are identified and electrocauterized or ligated. The fracture site is identified. The knee joint will need to be exposed via an arthtotomy. The articular surface identified by direct visualization. This requires extending the incision more distally. Anatomic reduction will be required. This will be achieved by manipulation of the fracture fragments and then placement of provisional K-wires and then lag screws to hold them into place, and then an additional buttress plate will be applied to the lateral cortex in order to provide additional stability. The reduction will be checked in AP and lateral views to insure that both the articular surface has been congruently replaced and that the fracture reduction sits in an anatomic position. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the fascia lata is reapproximated using interrupted suture and then subcutaneous tissue and skin are reapproximated .

Description of Post-Service Work: Post-service work: in facility
- Range of motion is checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee brace are applied.

The limb is positioned in a CPM machine.

- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

- Procedure note is written in the patient chart
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity

Redress wound

Order occupational therapy

- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association				
CPT Code:	27514				
Sample Size: 150	**Resp N:** 42	**Response:** 28.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**2.00**	4.00	50.00
Survey RVW:	13.00	17.43	**19.79**	22.00	30.00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	50.00	81.00	**90.00**	120.00	180.00
Immediate Post Service-Time:	**20.00**				

CPT Code: 27514

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	115.0	99231x 1.0 99232x 1.0 99233x 1.0
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, **if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.**

CPT Code: 27514		
		Specialty Recommended
Physician Work RVU:		17.43
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	100.0	99231x 1.0 99232x 2.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

'T Descriptor

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

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)	CPT Code: 27514	Key Reference CPT Code: 27236	Source of Time RUC Time
Median Pre-Service Time	90.00	90.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**409.00**	**473.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.13	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.00
Urgency of medical decision making	3.25	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.13
Physical effort required	3.50	3.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.25	3.38
Outcome depends on the skill and judgment of physician	3.63	3.25
Estimated risk of malpractice suit with poor outcome	3.25	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.25	3.13
Post-Service intensity/complexity	3.13	3.13

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, especially with respect to the primary provider subspecialty - trauma, since the AMA Masterfile did not delineate orthopaedic subspecialties. This may have led to an underestimation of post-service work in the Harvard survey.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared wit' the reference code and other orthopaedic services.

We are recommending a work RVU of 17.43 which is the 25% survey result with a IWPUT of .078 which is an (appropriately higher) IWPUT than the IWPUT of .060 for 27236, our key reference service. Our key comparison service was 27236, with a work RVU of 17.36, intra-service time of 90 minutes, four total post-operative hospital visit

days plus one discharge day, and four total post-operative office visit days with 3 99213's and 1 99212. The total time for our comparison code 27236 is 473. We felt the survey median RVU for 27248 of 19.79 was slightly higher than the procedure warrants. Our recommended valued of 17.43 is also lower than the current value for 27514 19.09 but we believe it is appropriate to lower the work RVU for this procedure. The 17.43 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27236, which has a RUC validated work RVU of 17.43 but has more post operative hospital visits than the surveyed code, 27514. The pre-service time for 27248 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27514 is 90 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending three total hospital visits, 1-99233, 1-99232 and 1-99231 plus one discharge day, 99238 which is consistent with the post-operative hospital visit package for other surveyed Hip and Knee Fracture codes. Finally, we are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 31% No 69%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27519 Tracking Number F38 Specialty Society Recommended RVU: **15.80**
Global Period: 090 RUC Recommended RVU: **15.80**

CPT Descriptor: Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-year-old boy falls and sustains a distal femoral epiphyseal separation with a large metaphyseal fragment requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: The leg is elevated and exsanguinated; the pneumatic tourniquet is inflated. An incision is made over the lateral side of the limb to the distal femur. The dissection is carried down to the fascia lata which is split in the line of direction of its fibers. The vastus lateralis is carefully elevated anteriorly with care being taken to identify the perforating vessels from the profunda femoris artery. Dissection is extremely cautious near the growth plate of the femur to minimize damage. The metaphyseal fragment is carefully identified. The fracture fragments are identified and then careful manipulation of the fracture fragments is performed in order to restore anatomic alignment of the fracture. Provisional fixation is done with K-wires. Subsequently, several cannulated screws may be applied to the metaphyseal fragment. In addition, smooth Steinmann pins are carefully placed from the medial and possibly the lateral femoral condyle in order to control rotation of the distal fragment to minimize damage of the growth plate. These may be left protruding out through the skin. The quality of the reduction is checked in AP and lateral radiographs. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and subcutaneous tissue and the skin are reapproximated in the standard manner.

Description of Post-Service Work: Post-service work: in facility
- Range of motion is checked at the end of the reduction to insure that it has been well restored and a dry ste dressing including compression and a knee brace are applied.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

- Procedure note is written in the patient chart
- The patient's vital signs are checked.

The circulation, sensation and motor function of the operated extremity are assessed.

- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy

Discuss progress with PCP (verbal and written)

Write medication prescriptions

- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association					
CPT Code:	27519					
Sample Size:	150	**Resp N:** 42	**Response:** 28.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	2.00	8.00
Survey RVW:		9.90	16.00	**18.00**	20.00	30.00
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
tra-Service Time:		40.00	60.00	**80.00**	90.00	150.00
mediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x **1.0**	99232x	99233x **1.0**		

Discharge Day Mgmt:	**0.0**	99238x **1.00** 99239x
Office time/visit(s):	**0.0**	99211x 12x **2.0** 13x **2.0** 14x 15x
Prolonged Services:	**0.0**	99354x 55x 56x 57x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(
99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (3

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27519		
		Specialty Recommended
Physician Work RVU:		15.80
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		80.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 26.1 %

TIME ESTIMATES (Median)

	CPT Code: 27519	Key Reference CPT Code: 27236	Source of Time RUC Time
Median Pre-Service Time	90.00	90.00	
Median Intra-Service Time	80.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**359.00**	**473.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.20
Urgency of medical decision making	3.82	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	4.18	3.70
Physical effort required	3.73	3.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.91	3.60
Outcome depends on the skill and judgment of physician	4.18	3.70
Estimated risk of malpractice suit with poor outcome	4.18	3.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.40
Intra-Service intensity/complexity	3.90	3.30
Post-Service intensity/complexity	4.00	3.60

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

  Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, especially with respect to the primary provider subspecialty - trauma, since the AMA Masterfile did not delineate orthopaedic subspecialties. This may have led to an underestimation of post-service work in the Harvard survey.

  Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

- ***Evidence that technology has changed physician work.***

  Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more

difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

We are recommending a work RVU of 15.80 which is the current value for 27519 and is very near the 25th percentile survey RVU of 16.00. This yields a IWPUT of .085 which is an (appropriately higher) IWPUT than the IWPUT of .060 for 27236, our key reference service. Our key comparison service was 27236, with a work RVU of 17.36, intra-service time of 90 minutes, four total post-operative hospital visit days plus one discharge day, and four total post-operative office visit days with 3 99213's and 1 99212. The total time for our comparison code 27236 is 473. We felt the survey median RVU for 27519 of 18.00 was higher than the procedure warrants and that the 25th percentile value of 16.00 was closer to the appropriate value but still slightly high. The 15.80 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27236, which has a RUC validated work RVU of 17.43 but has more post operative hospital visits than the surveyed code, 27519. The pre-service time for 27519 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27248 is 80 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending two total hospital visits, 1-99233 (the first day visit which is typically a longer and more intense patient visit than the subsequent day's hospital visit) and 1-99231 plus one discharge day, 99238 which is slightly different than the post-operative hospital visit package for other surveyed Hip and Knee Fracture codes but is warranted in this procedure as the typical patient is discharged after two days in the hospital. Finally, we are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 21% No 79%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27535 Tracking Number F39 Specialty Society Recommended RVU: **16.00**
Global Period: 090 RUC Recommended RVU: **16.00**

CPT Descriptor: Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old female falls and sustains a medial tibial plateau fracture requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an anterior midline incision is made. The dissection is carried down to the medial portion of the proximal tibia taking care to identify the patellar tendon and the pes anserine tendons and the tibial collateral ligament. The fracture site is identified. The portions of the tibial collateral ligament and the pes anserine tendons are carefully reflected off of the medial surface of the tibia. An arthrotomy is performed to look at the articular surface of the knee. Subsequently, a provisional reduction of the medial tibial plateau is performed with K-wires and is confirmed fluoroscopically. A proper plate is identified and bent using bending irons in order to conform to the medial portion of the tibia. Screws are placed in standard compression fashion across the fracture at the proximal tibia and extending down the shaft of the tibia. The overall length of the incision is approximately 15 cm. The quality of the reduction is checked with radiographs of the knee. An AP and lateral radiograph of the knee are obtained which are tangential to the articular surface and then the quality of the fracture reduction is separately checked with AP and lateral images of the tibia. The length of the screws is checked as well. The wounds are irrigated, the tourniquet deflated, hemostasis is achieved, and the wound is closed in layers, primarily with the subcutaneous tissue and the si being reapproximated.

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

- Range of motion is checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee immobilizer are applied.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

- Procedure note is written in the patient chart
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity

Redress wound

- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association				
CPT Code:	27535				
Sample Size: 150	**Resp N:** 33	**Response:** 22.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	3.00	**7.00**	12.00	30.00
Survey RVW:	11.60	16.00	**18.00**	20.00	26.00
e-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	45.00	75.00	**90.00**	120.00	140.00

Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x 99232x **1.0** 99233x **1.0**
Discharge Day Mgmt:	0.0	99238x **1.00** 99239x
Office time/visit(s):	0.0	99211x 12x **2.0** 13x **2.0** 14x 15x
Prolonged Services:	0.0	99354x 55x 56x 57x

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27535		
		Specialty Recommended
Physician Work RVU:		16.00
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	80.0	99231x 0.0 99232x 2.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27236	090	17.43	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 27535	Key Reference CPT Code: 27236	Source of Time RUC Time
Median Pre-Service Time	90.00	90.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**389.00**	**473.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.56	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.56
Urgency of medical decision making	2.67	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.89	3.00
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.89	3.13
Outcome depends on the skill and judgment of physician	3.33	3.25
Estimated risk of malpractice suit with poor outcome	3.00	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.78	2.75
Intra-Service intensity/complexity	2.89	3.00
Post-Service intensity/complexity	2.56	2.63

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

  This code was never surveyed by Harvard. The current RVW is based on an Abt study that did not collect time and visit information, but "relative" RVW based on an algorithm.

  Given this information, we believe there is compelling evidence that the current value may be flawed and without evidence.

- ***Evidence that technology has changed physician work.***

  Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

  Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF code because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

We are recommending a work RVU of 16.00 25th percentile survey RVU. This yields a IWPUT of .074 which is an (appropriately higher) IWPUT than the IWPUT of .060 for 27236, our key reference service. Our key comparison service was 27236, with a work RVU of 17.36, intra-service time of 90 minutes, four total post-operative hospital vi days plus one discharge day, and four total post-operative office visit days with 3 99213's and 1 99212. The total tin for our comparison code 27236 is 473. We felt the survey median RVU for 27248 of 18.00 was higher than the procedure warrants and that the 25th percentile value of 16.00 represents the appropriate value. The 16.00 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27236, which has a RUC validated work RVU of 17.43 but has more post operative hospital visits than the surveyed

code. The pre-service time for 27519 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27248 is 90 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending three total hospital visits plus one discharge day with values of 1-99233 (the first day visit which is ypically a longer and more intense patient visit than the subsequent day's hospital visit) and 1-99232 plus one discharge day, 99238 which is slightly different than the post-operative hospital visit package for other surveyed Hip and Knee Fracture codes but is warranted in this procedure as the typical patient is discharged after two days in the hospital. Finally, we are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 31% No 69%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 9% no change 91%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27540 Tracking Number F40 Specialty Society Recommended RVU: **13.45**
Global Period: 090 RUC Recommended RVU: **13.45**

CPT Descriptor: Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 13-year-old boy sustains an intercondylar spine fracture when a heavy object falls on his outstretched leg requiring open reduction and internal fixation..

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regula drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an anterior midline incision is made. An anterior medial arthrotomy is made into the knee. The hematoma is carefully evacuated and washed out. The fracture fragments are identified. The knee is inspected for damage to the lateral medial menisci and the cruciate ligaments. The fracture fragments are carefully identified and the intercondylar spine fracture is anatomically reduced provisionally with a K-wire. Subsequently, wires are passed from the proximal tibia into the intercondylar eminence fragment which allow passage of heavy sutures in order to compress to anchor this, and then additional screws are placed from the intercondylar fragment into the proximal metaphysis of the tibia. These are cannulated screws requiring placement of a K-wire, then confirmation of anatomic reduction of the fragment, and then placement of the screw into the fragment compressing the fragment into place. After the entire fixation has been done, the knee is carefully washed out. The quality of the reduction is checked with radiographs. The range of motion of the knee is examined. The stability of the knee is examined. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the me parapatellar arthrotomy is reapproximated using a stout suture. The subcutaneous tissue and skin are reapproxima

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

- Range of motion is checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee immobilizer are applied.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

- Procedure note is written in the patient chart
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association				
CPT Code:	27540				
Sample Size:	150	**Resp N:** 43	**Response:** 28.6 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**1.00**	2.00	12.00
Survey RVW:	9.00	14.00	**16.00**	18.33	26.90
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	45.00	60.00	**75.00**	90.00	222.00

Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x 99232x 99233x **1.0**
Discharge Day Mgmt:	0.0	99238x **1.00** 99239x
Office time/visit(s):	0.0	99211x 12x **1.0** 13x **3.0** 14x 15x
Prolonged Services:	0.0	99354x 55x 56x 57x

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27540		
		Specialty Recommended
Physician Work RVU:		13.45
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		75.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 0.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

EY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29883	090	11.61	RUC Time

CPT Descriptor Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 23.2 %

TIME ESTIMATES (Median)

	CPT Code: 27540	Key Reference CPT Code: 29883	Source of Time RUC Time
Median Pre-Service Time	90.00	75.00	
Median Intra-Service Time	75.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**334.00**	**311.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.11	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.89	3.00
Urgency of medical decision making	2.67	2.11

Technical Skill/Physical Effort (Mean)

Technical skill required	3.78	3.56
Physical effort required	2.89	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.89
Outcome depends on the skill and judgment of physician	3.56	3.56
Estimated risk of malpractice suit with poor outcome	3.56	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.56	2.78
Intra-Service intensity/complexity	3.44	3.44
Post-Service intensity/complexity	2.89	3.11

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, especially with respect to the primary provider subspecialty - trauma, since the AMA Masterfile did not delineate orthopaedic subspecialties. This may have led to an underestimation of post-service work in the Harvard survey.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared wi the reference code and other orthopaedic services.
We are recommending a work RVU of 14.00 which is the 25% survey result. Our key comparison service was 29883, with a work RVU of 11.61, intra-service time of 90 minutes, one full hospital discharge day, and four total post-operative office visit days with 2 99213's and 2 99212. We felt the survey median RVU for 27540 of 16.00 was higher than the procedure warrants and would not have maintained a rank order relativity with other Hip and Knee Fracture

codes. The 14.00 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 29883, which has a RUC validated work RVU of 11.61 but has more intra-service time (appropriate because 27540 does not take quite as long) and an appropriately lower IWPUT of .058 compared to the IWPUT for our recommended values, which is .075 which we believe is correct for 27540. The pre-service time for 7540 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27540 is 75 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending one hospital visits plus one discharge day, 99238. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 30% No 70%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 31% I do not agree 69%
B. Patients requiring this service are now:
   more complex (more work) 62% less complex (less work) 0% no change 38%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 8% no change 92%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27556 Tracking Number F41 Specialty Society Recommended RVU: **15.50**
Global Period: 090 RUC Recommended RVU: **15.50**

CPT Descriptor: Open treatment of knee dislocation, with internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male falls and dislocates his knee requiring open reduction. [Note: Internal fixation, when performed, is included in the work of this procedure. External fixation, when performed, would be reported separately.].

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, attempts at closed reduction are made, with reduction not possible because the femoral condyle is buttonholed through the fascia lata. An anterior midline incision is made which allows exposure of these structures. A cautious release of some of the fascia lata is performed. This allows reduction of the knee. The arthrotomy also permits inspection of the inside of the knee and allows removal of loose osteochondral fragments. The knee is carefully irrigated. Hemostasis is again achieved. The stability of the limb is gently tested in order to assess stable positions for the knee. The range of motion of the knee is checked. The quality of the reduction is checked either with a fluoroscopy or with a plain film. The stability of the newly reduced knee can be held acceptably. No further fixation is applied. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the incision is closed with the ligamentous portion of the knee being reapproximated, subcutaneous tissue and skin being reapproximated.

Description of Post-Service Work: Post-service work: in facility
- Range of motion is gently checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee immobilizer are applied.
- Monitor patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

Procedure note is written in the patient chart

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This may require removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy

Supervision of rehabilitation

Monitor physical therapy

- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association					
CPT Code:	27556					
Sample Size:	150	**Resp N:**	37	**Response:** 24.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	1.00	3.00
Survey RVW:		9.00	15.50	**18.00**	21.00	30.00
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**15.0**		
-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		10.00	60.00	**90.00**	120.00	150.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				

CPT Code: 27556

Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x **1.0** 99232x 99233x **1.0**
Discharge Day Mgmt:	0.0	99238x **1.00** 99239x
Office time/visit(s):	0.0	99211x 12x **1.0** 13x **3.0** 14x 15x
Prolonged Services:	0.0	99354x 55x 56x 57x

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27556		
		Specialty Recommended
Physician Work RVU:		15.50
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27415	090	19.79	RUC Time

CPT Descriptor Osteochondral allograft, knee, open)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 18.9 %

TIME ESTIMATES (Median)

	CPT Code: 27556	Key Reference CPT Code: 27415	Source of Time RUC Time
Median Pre-Service Time	90.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**369.00**	**424.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.75
Urgency of medical decision making	4.83	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	4.25
Physical effort required	4.33	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.50	4.00
Outcome depends on the skill and judgment of physician	4.67	4.25
Estimated risk of malpractice suit with poor outcome	4.50	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.75
Intra-Service intensity/complexity	4.00	4.25
Post-Service intensity/complexity	3.50	3.75

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, especially with respect to the primary provider subspecialty - trauma, since the AMA Masterfile did not delineate orthopaedic subspecialties. This may have led to an underestimation of post-service work in the Harvard survey.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

We are recommending a work RVU of 15.50 which is the 25% survey result. Our key comparison service was 27415, with a work RVU of 19.79, intra-service time of 120 minutes, two post-operative hospital visits plus one full hospital discharge day, and five total post-operative office visit days with 2 99213's and 2 99212. We felt the survey median

RVU for 27540 of 18.00 was higher than the procedure warrants and would not have maintained a rank order relativity with other Hip and Knee Fracture codes. The 15.50 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27415, which has a RUC validated work RVU of 19.79 with more intra-service time, and more post-operative hospital visits (appropriate because 27556 does not take quite as ng) and an appropriately higher IWPUT of .088 compared to the IWPUT for our recommended values, which is .083 which we believe is correct for 27556. The pre-service time for 27557 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27556 is 90 minutes, which we believe is appropriate. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending two total hospital visits, 1-99233 (the first day visit which is typically a longer and more intense patient visit than the subsequent day's hospital visit) and 1-99231 plus one discharge day, 99238 which is the same post-operative hospital visit package for the other surveyed Hip and Knee Fracture codes that are most similar to this procedure. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 19% No 81%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 14% I do not agree 86%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27557 Tracking Number F42 Specialty Society Recommended RVU: **19.00**
Global Period: 090 RUC Recommended RVU: **19.00**

CPT Descriptor: Open treatment of knee dislocation, with internal fixation, when performed; with primary ligamentous repair

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 18-year-old male falls and dislocates his knee. The anterior cruciate ligament is avulsed with a fragment of bone. Open reduction with primary ligamentous repair is performed. [Note: Internal fixation, when performed, is included in the work of this procedure. External fixation, when performed, would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, attempts at closed reduction are made, with reduction not possible because the femoral condyle is buttonholed through the fascia lata. An anterior midline incision is made which allows exposure of these structures. A cautious release of some of the fascia lata is performed. This allows reduction of the knee. The arthrotomy also permits inspection of the inside of the knee and allows removal of loose osteochondral fragments. During the arthrotomy, the anterior cruciate ligament is noted to be avulsed with a bony fragment. These fracture fragments are large enough that they warrant an attempt at internal fixation. The fragment is too small to allow placement of large screws. Subsequently, the fractured fragment is held anatomically reduced and a K-wire is carefully directed to allow placement of two sutures into the fractured fragment, thus a suture is passed from the proximal medial tibia into the knee joint itself. It is then sutured to anchor the anterior cruciate ligament and the bony fragment, and th brought back through a separate tunnel and then tightly tied around a screw and a washer. This is used to hold ruptured anterior cruciate ligament and bony fragment in anatomic position. The knee is then checked fluoroscopically fo quality of the reduction and gentle ligamentous stability testing is performed. The wounds are irrigated, the to tiquet is deflated, hemostasis is achieved, and the medial parapatellar arthrotomy is then reapproximated. Subcutaneous tissue and skin are reapproximated.

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

- Range of motion is checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee immobilizer are applied.

Monitor patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

- Procedure note is written in the patient chart
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings

Assessment of surgical wound

Remove sutures

- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD		
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association		
CPT Code:	27557		
Sample Size:	150	**Resp N:** 37	**Response:** 24.6 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
rvice Performance Rate	0.00	0.00	**0.00**	2.00	50.00
urvey RVW:	15.00	19.00	**21.61**	24.00	35.00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		

CPT Code: 27557

Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	90.00	**120.00**	150.00	300.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x **1.0**	99232x	99233x **1.0**		
Discharge Day Mgmt:	**0.0**	99238x **1.00**	99239x			
Office time/visit(s):	**0.0**	99211x	12x **1.0**	13x **3.0**	14x	15x
Prolonged Services:	**0.0**	99354x	55x	56x	57x	

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27557		
		Specialty Recommended
Physician Work RVU:		19.00
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27415	090	19.79	RUC Time

CPT Descriptor Osteochondral allograft, knee, open)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 13.5 %

TIME ESTIMATES (Median)

	CPT Code: 27557	Key Reference CPT Code: 27415	Source of Time RUC Time
Median Pre-Service Time	90.00	75.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**399.00**	**424.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.67
Urgency of medical decision making	4.60	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	4.00
Physical effort required	4.40	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.40	3.50
Outcome depends on the skill and judgment of physician	4.20	4.17
Estimated risk of malpractice suit with poor outcome	4.40	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.40	3.33
Intra-Service intensity/complexity	4.40	4.00
Post-Service intensity/complexity	3.80	3.33

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, especially with respect to the primary provider subspecialty - trauma, since the AMA Masterfile did not delineate orthopaedic subspecialties. This may have led to an underestimation of post-service work in the Harvard survey.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), ~~a~~ major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared wit the reference code and other orthopaedic services.
We are recommending a work RVU of 19.00 which is the 25% survey result. Our key comparison service was 27415, with a work RVU of 19.79, intra-service time of 120 minutes, two post-operative hospital visits plus one full hospital discharge day, and five total post-operative office visit days with 2 99213's and 2 99212. We felt the survey median RVU for 27540 of 21.61 was higher than the procedure warrants and would not have maintained a rank order relativity

with other Hip and Knee Fracture codes. The 19.00 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27415, which is very similar in value to the RUC validated work RVU of 19.79. Our recommended value yields a IWPUT of .091 which is very similar our comparison code, 27415, IWPUT of .088. The pre-service time for 27248 is 15 minutes for evaluation time, 15 minutes positioning and 5 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27557 is 120 minutes, which we believe is appropriate and maintains relatively within the Hip and Knee Fracture family. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending two total hospital visits, 1-99233 (the first day visit which is typically a longer and more intense patient visit than the subsequent day's hospital visit) and 1-99231 plus one discharge day, 99238 which is the same post-operative hospital visit package for the other surveyed Hip and Knee Fracture codes that are most similar to this procedure. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 30% No 70%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 36% I do not agree 64%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27558 Tracking Number F43 Specialty Society Recommended RVU: **22.00**
Global Period: 090 RUC Recommended RVU: **22.00**

CPT Descriptor: Open treatment of knee dislocation, with internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female sustains a right knee dislocation requiring open reduction and primary repair of the lateral collateral ligament and hamstring reconstruction of her anterior cruciate ligament. [Note: Internal fixation, when performed, is included in the work of this procedure. External fixation, when performed, would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, attempts at closed reduction are made, with reduction not possible because the femoral condyle is buttonholed through the fascia lata. An anterior midline incision is made which allows exposure of these structures. A cautious release of some of the fascia lata is performed. This allows reduction of the knee. The arthrotomy also permits inspection of the inside of the knee and allows removal of loose osteochondral fragments. During the arthrotomy, the anterior cruciate ligament is noted to be avulsed with a bony fragment. These fracture fragments are large enough that they warrant an attempt at internal fixation. The fragment is too small to allow placement of large screws. Subsequently, the fractured fragment is held anatomically reduced and a K-wire is carefully directed to allow placement of two sutures into the fractured fragment, thus a suture is passed from the proximal medial tibia into the knee joint itself. It is then sutured to anchor the anterior cruciate ligament and the bony fragment, and t brought back through a separate tunnel and then tightly tied around a screw and a washer. This is used to hold . ruptured anterior cruciate ligament and bony fragment in anatomic position. For harvesting of the medial hamstring tendons for reconstruction, the anterior midline incision is extended distally. The semitendinosus tendon is identified and is dissected posteriorly towards the popliteal space of the knee. A tendon stripper is then placed over the tendon and is advanced deep into the thigh in order to harvest the greatest length of semitendinosus tendon possible. This graft is then

carefully prepared for reconstruction of the posterior cruciate ligament in the posterior aspect of the knee. This semitendinosus tendon is used to reconstruct the anterior cruciate ligament with a quadruple stranded tendon repair. The bony fragment of the posterior cruciate ligament is carefully identified and is repaired by passing sutures into it from the anterior portion of the tibia passing the suture into the fractured fragment, and this proves to be exceptionally difficult because of the limited ability to dissect posteriorly, and this is anchored with a single #5 Ethibond suture posteriorly. The quality of the reduction is checked fluoroscopically. The ligamentous stability is gently tested. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the anterior midline incision and arthrotomy are reapproximated, and the skin is closed.

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

- Range of motion is gently checked at the end of the reduction to insure that it has been well restored and a dry sterile dressing including compression and a knee immobilizer are applied.
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

Dictation of an operative report

- Procedure note is written in the patient chart
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered

Write prescriptions for medications needed post-discharge.

All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	R. Dale Blasier, MD, FACS William Creevy, MD		
Specialty(s):	American Academy of Orthopaedic Surgeons Orthopaedic Trauma Association		
CPT Code:	27558		
Sample Size: 150	**Resp N:**	37	**Response:** 24.6 %

CPT Code: 27558

Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	**1.00**	2.00	6.00
Survey RVW:		15.00	22.00	**25.00**	30.00	42.00
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		90.00	120.00	**150.00**	200.00	360.00
Immediate Post Service-Time:	20.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	75.0	99231x **1.0** 99232x **0.0** 99233x **1.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	85.0	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27558		
		Specialty Recommended
Physician Work RVU:		22.00
Pre-Service Evaluation Time:		60.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		150.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27134	090	30.13	RUC Time

CPT Descriptor Revision of total hip arthroplasty; both components, with or without autograft or allograft

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 24.3 %

TIME ESTIMATES (Median)

	CPT Code: 27558	Key Reference CPT Code: 27134	Source of Time RUC Time
Median Pre-Service Time	90.00	90.00	
Median Intra-Service Time	150.00	240.00	
Median Immediate Post-service Time	20.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**429.00**	**617.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.56	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	4.50
Urgency of medical decision making	5.00	3.83

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	5.00
Physical effort required	4.56	4.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.67	4.83
Outcome depends on the skill and judgment of physician	5.00	5.00
Estimated risk of malpractice suit with poor outcome	4.22	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.33	4.83
Intra-Service intensity/complexity	4.50	4.83
Post-Service intensity/complexity	3.83	4.17

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

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data***

  This code was never surveyed by Harvard. The current RVW is based on an Abt study that did not collect time and visit information, but "relative" RVW based on an algorithm.

  Given this information, we believe there is compelling evidence that the current value may be flawed and without evidence.

- ***Evidence that technology has changed physician work.***

  Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

  Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

A survey was sent to orthopaedic surgeons representing orthopaedic trauma, general orthopaedics, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services.

We are recommending a work RVU of 22.00 which is the 25% survey result. Our key comparison service was 271 with a work RVU of 30.13, intra-service time of 240 minutes, seven post-operative hospital visits plus one full hosp. discharge day, and three 99213 post-operative office visit days. We felt the survey median RVU for 27540 of 25.00 was higher than the procedure warrants and would not have maintained a rank order relativity with other Hip and Knee Fracture codes. The 22.00 value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference service, 27134 with a higher work RVU of 30.13 but with significantly more intra-service time

at 240 and a much longer hospital visit time of 7 days plus one discharge day. Our recommended value yields a IWPUT of .092 which maintains relativity with the IWPUTs for the other Hip and Knee Fracture codes. The pre-service time for 27248 is 15 minutes for evaluation time, 15 minutes positioning and 15 minutes scrub, dress and wait time. The median intra-service (skin-to-skin) time for 27557 is 150 minutes, which we believe is appropriate and maintains relatively within the Hip and Knee Fracture family. The survey immediate post service time was 20 minutes, which again we believe to be appropriate. We are recommending two total hospital visits, 1-99233 (the first day visit which is typically a longer and more intense patient visit than the subsequent day's hospital visit) and 1-99231 plus one discharge day, 99238 which is the same post-operative hospital visit package for the other surveyed Hip and Knee Fracture codes that are most similar to this procedure. We are recommending 4 post-operative office visits, 2-99213 and 2-99212, which is consistent with the recommended post-operative office visits for many of the other Hip and Knee Fracture codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 36% No 64%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 92% less complex (less work) 0% no change 8%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 8% no change 92%

CPT Code: 27248,27511,27513,27514,27519,27535,27540,27556,27557,27558

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

27248 Open treatment of greater trochanteric fracture, includes internal fixation, when performed
27511 Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed
27513 Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
27514 Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
27519 Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed
27535 Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
27540 Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed
27556 Open treatment of knee dislocation, with internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction
27557 Open treatment of knee dislocation, with internal fixation, when performed; with primary ligamentous repair
27558 Open treatment of knee dislocation, with internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management services.

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				F34		F35		F36		F37		F38	
2				27248		27511		27513		27514		27519	
3	**Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation**			Open treatment of greater trochanteric fracture, includes internal fixation, when performed		Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed		Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed		Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed		Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed	
4	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			N/A	90	N/A	90	N/A	90	N/A	90	N/A	90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	129	N/A	129	N/A	129	N/A	129	N/A	129
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12	N/A	12	N/A	12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	117	N/A	117	N/A	117	N/A	117	N/A	117
10	PRE-SERVICE												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA										
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA										
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA										
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA										
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA										
18	**End: When patient enters office/facility for surgery/procedure**												
19	SERVICE PERIOD												
20	**Start: When patient enters office/facility for surgery/procedure**												
40	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D	RN/LPN/MTA		12		12		12		12		12
42	**End: Patient leaves office/FACILITY**												
43	POST-SERVICE PERIOD												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions												
47	*List Number and Level of Office Visits*												
48	99211 16 minutes		16										
49	99212 27 minutes	L037D	27		3		3		3		3		3
50	99213 36 minutes	L037D	36		1		1		1		1		1
51	99214 53 minutes		53										
52	99215 63 minutes		63										
53	*Total Office Visit Time*			0	117	0	117	0	117	0	117	0	117
54	Other Activity (please specify)												
55	**End: with last office visit before end of global period**												
56	MEDICAL SUPPLIES	Item Code	Qty										
57	pack, minimum multi-specialty visit	SA048	pack		4		4		4		4		4
58	pack, post-op incision care (suture)	SA054	kit		1		1		1		1		1
59	EQUIPMENT	Item Code											
60	table, power	EF031			135		135		126		126		126
61	light, exam	EQ168			135		135		126		126		126

610

	A	B	C	N	O	P	Q	R	S	T	U	V	W
1				F39		F4		F41		F42		r43	
2				27535		27540		27556		27557		27558	
3	**Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation**			Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed		Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed		Open treatment of knee dislocation, with internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction		Open treatment of knee dislocation, with internal fixation, when performed; with primary ligamentous repair		Open treatment of knee dislocation, with internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	
4	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			N/A	90	N/A	90	N/A	90	N/A	90	N/A	90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	129	N/A	189	N/A	129	N/A	129	N/A	129
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	0	N/A	60	N/A	0	N/A	0	N/A	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12	N/A	12	N/A	12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	117	N/A	117	N/A	117	N/A	117	N/A	117
10	PRE-SERVICE												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA				5						
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA				20						
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA				8						
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				20						
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				7						
18	**End: When patient enters office/facility for surgery/procedure**												
19	SERVICE PERIOD												
20	**Start: When patient enters office/facility for surgery/procedure**												
40	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D	RN/LPN/MTA		12		12		12		12		12
42	**End: Patient leaves office/FACILITY**												
43	POST-SERVICE PERIOD												
44	**Start: Patient leaves office/facility**												
45	Conduct phone calls/call in prescriptions												
47	*List Number and Level of Office Visits*												
48	99211 16 minutes		16										
49	99212 27 minutes	L037D	27		3		3		3		3		3
50	99213 36 minutes	L037D	36		1		1		1		1		1
51	99214 53 minutes		53										
52	99215 63 minutes		63										
53	*Total Office Visit Time*			0	117	0	117	0	117	0	117	0	117
54	Other Activity (please specify)												
55	**End: with last office visit before end of global period**												
56	MEDICAL SUPPLIES	HCPCS Code	Unit										
57	pack, minimum multi-specialty visit	SA048	pack		4		4		4		4		4
58	pack, post-op incision care (suture)	SA054	kit		1		1		1		1		1
59	EQUIPMENT	HCPCS Code											
60	table, power	EF031			126		135		135		135		135
61	light, exam	EQ168			126		135		135		135		135

611

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Open Knee Osteochondral Autograft

In February 2007, the CPT Editorial Panel created one new Category I CPT code to describe procedures not previously described in the family of osteochondral implantation CPT codes created in February 2004. These existing codes describe closed autograft, closed allograft, and open allograft techniques, but failed to describe open autograft technique. This new service describes the final combination of techniques.

The RUC reviewed the specialty society's survey results and recommendations for CPT code 27416, *Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])*. The RUC considered the surveyed code in comparison to the key reference service, 29866, *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)* (work RVU = 14.48). The RUC noted that the reference service has very similar pre-, intra- and post-service times. The reference service has slightly less pre-service time (75 versus 80 minutes) and slightly more intra-service time (100 versus 90 minutes), accounting for a difference in total time between the reference service and the surveyed service of only 5 minutes (292 versus 287 minutes). The survey results indicated a median of 19.00 work RVUs, which the specialty and RUC agreed was too high, given the similarity of the surveyed procedure with the reference service. The RUC concurred that the 25th percentile work RVU of 14.00 was appropriate for the work involved in the service and this value was below the reference service, maintaining proper rank order. Following some discussion, the RUC agreed that number and intensity of post-operative visits were appropriate (two 99213, two 99212, and 0.5 99238).

The RUC recommends the specialty society survey 25th percentile work RVU of 14.00 for code 27416.

Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
27415		Osteochondral allograft, knee, open (For arthroscopic implant of osteochondral allograft, use 29867) (Do not report 27415 in conjunction with 27416)	090	19.79 (No Change)
●27416	X1	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s]) (Do not report 27416 in conjunction with 27415, 29870, 29871, 29874, 29875, 29884 when performed at the same session and/or 29877, 29879, 29885-29887 when performed in the same compartment) (For arthroscopic osteochondral autograft of knee, use 29866)	090	14.00
Endoscopy/Arthroscopy				
29866		Arthroscopy, knee, surgical; osteochondral autografts (eg, mosaicplasty) (includes harvesting of autograft[s]) (Do not report 29866 in conjunction with 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment) (For open osteochondral autograft of knee, use 27416)	090	14.48 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27416 Tracking Number X1 Specialty Society Recommended RVU: **14.00**
Global Period: 090 RUC Recommended RVU: **14.00**

CPT Descriptor: Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 38-year-old woman with medial right knee pain of 4 months duration. She has been treated with anti-inflammatory medicines and physical therapy without improvement. Physical exam demonstrates normal alignment, a small joint effusion, medial joint line tenderness and no knee instability. Imaging studies reveal an isolated osteochondral defect of medial femoral condyle. Because of failure to respond to non-operative measures, an open osteochondral autograft is performed.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Sign the operative site
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- Position the extremity, padding any bony prominence and bolstering as necessary
- Indicate areas of skin to be prepped and mark surgical incisions
- Apply a protective wrap and then the tourniquet
- Prep and drape the extremity
- Exsanguinate the leg if desired and inflate the tourniquet
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an arthrotomy is made to access the compartment in question. The osteochondral defect is debrided and prepared for transplantation. The donor site is visualized and the harvest device is carefully directed into the donor site tissue. Exact perpendicularity of the harvest device to the articular surface is mandatory. Once the tissue is harvested the recipient site is prepared with an appropriate sized drill to match the harvested tissue. The harvested osteochondral graft is then inserted into the articular surface defect which was "standardized" with the drill. Great care is taken to correctly orient the osteochondral autograft as it is forced into the original osteochondral defect. Once correctly placed, the procedure is repeated until the defect is filled or the available donor tissue is exhausted. The wounds are irrigated, the tourniquet is deflated, hemostasis is achieved, and the incision closed

Description of Post-Service Work: Post-service work: in facility
- Apply a sterile lightly compressive dressing and knee immobilizer or hinged brace
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.

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

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Beach, MD				
Specialty(s):	AAOS, AANA				
CPT Code:	27416				
Sample Size: 150	**Resp N:** 34	**Response:** 22.6 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**2.00**	5.00	25.00
Survey RVW:	10.00	14.00	**19.00**	20.00	25.00
Pre-Service Evaluation Time:			**55.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	60.00	71.00	**90.00**	100.00	180.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 27416		
		Specialty Recommended
Physician Work RVU:		14.00
Pre-Service Evaluation Time:		55.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

; the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29866	090	14.48	RUC Time

CPT Descriptor Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 44.1 %

TIME ESTIMATES (Median)

	CPT Code: 27416	Key Reference CPT Code: 29866	Source of Time RUC Time
Median Pre-Service Time	80.00	75.00	
Median Intra-Service Time	90.00	100.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**287.00**	**292.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.87	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.75
Urgency of medical decision making	2.80	3.13

Technical Skill/Physical Effort (Mean)

Technical skill required	4.27	4.50
Physical effort required	3.67	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.53	3.63
Outcome depends on the skill and judgment of physician	4.13	4.00

Estimated risk of malpractice suit with poor outcome	3.13	3.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.21	3.56
Intra-Service intensity/complexity	3.79	4.22
Post-Service intensity/complexity	3.14	3.22

Additional Rationale

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

A survey was sent to orthopaedic surgeons representing general orthopaedics, arthroscopy, and hip & knee surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services. The panel agreed that the arthroscopic procedure may require slightly more intra time (100 vs 90 minutes). The panel also agreed that that the total work for both the survey code and reference code are very comparable. Based on this discussion, the survey 25th percentile RVW of 14.00 is recommended. This value correctly sets this new code slightly less than the reference code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlist code is reviewed) 27599

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

Specialty AAOS How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of requestor

Specialty Orthopaedic Surgery Frequency 200 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of requestor

Specialty Orthopaedic Surgery Frequency 100 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

27416 Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey code relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 6 minutes has been applied for this outpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedures each have 2 x 99212 and 2 x 99213 visit. The standard times have been applied for post-service clinical labor time.

	A	B	C	D	E
1				27416	
2	**Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation**			**Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])**	
3	**LOCATION**	**Code**	**Staff Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**N/A**	**90**
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**192**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**60**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**6**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**126**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA		**5**
12	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA		**20**
13	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**
14	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**20**
15	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**7**
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
39	Discharge day management 99238 --12 minutes 99239 --15 minutes	**L037D**	RN/LPN/MTA		**6**
41	**End: Patient leaves office/FACILITY**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes	**L037D**	27		**2**
49	99213 36 minutes	**L037D**	36		**2**
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53					
54	*Total Office Visit Time*			**0**	**126**
55	Other Activity (please specify)				
56	**End: with last office visit before end of global period**				
57	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
58	pack, minimum multi-specialty visit	**SA048**	**pack**		**4**
59	pack, post-op incision care (suture)	**SA054**	**kit**		**1**
60					
61					
62	**Equipment**	**CMS Code**	**Utilization Percentage**		
63	table, power	**EF031**	**100%**		**126**
64	light, exam	**EQ168**	**100%**		**126**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Posterior Malleolar Fracture Treatment

In February 2007, the CPT Editorial Panel created three new Category I CPT codes to describe treatment of isolated, posterior malleolar fractures. Such treatments are recognized as being important in maintaining ankle joint stability and preventing or delaying the onset of degenerative arthritis. Prior to the creation of these codes, there were no codes describing closed or percutaneous treatment of these fractures, though codes exist for the treatment of a posterior malleolar fracture only when this fracture occurs with another malleolar injury (i.e., a lateral malleolus fracture or a medial malleolus fracture ("bimalleolar" fracture) or both together ("trimalleolar" pattern)). This fracture is now recognized to occur in isolation (i.e. without involvement of either the lateral or medial malleolus). These three new codes were established to describe treatment for these isolated injuries.

625

27767

The RUC reviewed the specialty societies' survey results and presentation for CPT code 27767, *Closed treatment of posterior malleolus fracture; without manipulation.* The RUC compared the surveyed code to the reference service code, 27808, *Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation*, (work RVU = 2.91) and noted that the reference service had significantly more intra-service time than the surveyed code (15 minutes versus 37 minutes). The specialty societies commented that the physician time for code 27808 was not reviewed by the RUC and stated that the work described was similar and the intensity and complexity of both services were comparable. The RUC found that 26600, *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU = 2.48) was a more suitable reference code (included on the survey's reference service list). Code 26600 has been reviewed by the RUC and describes similar work. Additionally, the RUC reviewed intra-service time is identical to the surveyed code and each contains four office visits within their global periods. The total time for the surveyed code is slightly higher (96 minutes) than code 26600 (93 minutes). In tandem with this appropriate reference code, the survey's 25th percentile work RVU was 2.50, which the RUC agreed was the appropriate work RVU for 27767.

The RUC recommends the survey 25th percentile work RVU of 2.50 for code 27767.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

27768

The RUC reviewed the specialty societies' survey results and presentation for CPT code 27768, *Closed treatment of posterior malleolus fracture; with manipulation*. The RUC compared the surveyed code to the reference service code, 27810, *Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation* (work RVU = 5.20) and noted that the reference service had significantly more intra-service time than the surveyed code (25 minutes versus 52 minutes). The specialty societies commented that the physician service times for 27810 were not previously reviewed by the RUC, however, the work described was similar. Further, the surveyed code requires greater intensity and complexity than the reference service, particularly in mental effort and judgment, technical skill and physical effort, and psychological stress. The reference service and surveyed service require comparable pre- and post-service times (45 minutes versus 34 minutes) and nearly identical post-service time (10 minutes versus 11 minutes). Comparable to the reference service, the RUC agreed that the survey median of 5.00 work RVUs was appropriate for 27768.

The RUC recommends the survey median work RVU of 5.00 for code 27768.

27769

The RUC reviewed the specialty societies' survey results and presentation for CPT code 27769, *Open treatment of posterior malleolus fracture; includes internal fixation, when performed*. The RUC compared the surveyed code to the reference service code, 25607, *Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation* (work RVU = 9.35). The RUC noted the similarity in pre-, intra-, and post-service times between the surveyed code and the reference code, 75, 60, and 15 minutes, versus 65, 60, and 30 minutes, respectively. The surveyed code also requires greater technical skill and physical effort as well as greater intra- and post- service time intensity/complexity. Given, the similarities, the RUC agreed that the reference service code was appropriate. The RUC also considered in-depth, the specialties' survey, noting that the survey was randomized with a relatively high number of responses (n = 48) and a sound response rate (24%). The RUC agreed that the tight distribution of work RVUs between the 25th and 75th percentiles gave credence to the survey median work RVU of 10.00. The RUC did, however, concur that the intensity of the office visits within the service's global period were overstated in the survey results. The RUC and the specialty societies agreed that the four visits were appropriate, but the visits should consist of three 99212 and only one 99213 office visits. The RUC recommends a pre-service time of 75 minutes, intra-service time of 60 minutes, and immediate post-service time of 15 minutes for code 27769.

The RUC recommends the survey median work RVU of 10.00 for code 27769.

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Practice Expense

The RUC recommends the practice expense inputs as amended in the non-facility setting for 27767, removing duplicative clinical staff time as well as the specialty societies' recommended inputs for 27768 and 27769, facility-only procedures, as they are standard 090 day global inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●27767	Y1	Closed treatment of posterior malleolus fracture; without manipulation	090	2.50
●27768	Y2	with manipulation	090	5.00
●27769	Y3	Open treatment of posterior malleolus fracture, includes internal fixation, when performed (Do not report 27767-27769 in conjunction with 27808-27823)	090	10.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27767 Tracking Number Y1 Specialty Society Recommended RVU: **2.50**
Global Period: 090 RUC Recommended RVU: **2.50**

CPT Descriptor: Closed treatment of posterior malleolus fracture; without manipulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman presents with ankle pain after a fall. Physical examination and imaging studies demonstrate a [non]displaced fracture of the posterior malleolus. The fracture is treated without manipulation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Monitor/assist with patient positioning and padding of bony prominences to allow access of fluoroscopy equipment

Description of Intra-Service Work: After careful positioning by the physician, the physician confirms the stability & position of the fracture, then holds the foot and a cast is applied from calf to the toes, including applying the padding. While the casting material is setting, the cast is molded to maintain anatomic position of the fracture without compromising the skin or neurovascular structures.

Description of Post-Service Work: • Assess circulation, sensation and motor function of the extremity
- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Order periodic x-rays
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; William Beach, MD				
Specialty(s):	AAOS/OTA, AOFAS				
CPT Code:	27767				
Sample Size: 200	**Resp N:** 48	**Response:** 24.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**4.00**	6.00	30.00
Survey RVW:	2.00	2.50	**2.91**	3.00	8.50
Pre-Service Evaluation Time:			**0.0**		

CPT Code: 27767

Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	15.00	**15.00**	20.00	45.00
nmediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in t. following table, and tab through to the new technology/service box.

CPT Code: 27767		
		Specialty Recommended
Physician Work RVU:		2.50
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		5.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		15.00
Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27808	090	2.91	Harvard Time

CPT Descriptor Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 54.1 %

TIME ESTIMATES (Median)	CPT Code: 27767	Key Reference CPT Code: 27808	Source of Time Harvard Time
Median Pre-Service Time	5.00	16.00	
Median Intra-Service Time	15.00	37.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	71.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**96.00**	**127.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	2.19	2.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.69	1.71
Physical effort required	1.69	1.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.81	1.79
ıtcome depends on the skill and judgment of physician	2.19	2.08
Estimated risk of malpractice suit with poor outcome	2.27	2.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.96	2.00
Intra-Service intensity/complexity	1.81	1.83
Post-Service intensity/complexity	1.81	1.83

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The AAOS, OTA and AOFAS convened an expert panel to review the survey results for 27767. We are recommending a work RVU of 2.91 which is the median survey work RVU and we believe appropriately values this service. Our survey respondents choose 27808 as the key reference service and 27808 has a 2.91 work RVU. We believe these two procedures to be very similar in terms of work and intensity and the surveys results confirm that. Our survey respondents indicated a total time for this procedure of 96 minutes distributed as follows: 5 minutes of positioning time, 15 minutes intra-service time, 5 immediate post service time and four post-service office visits, 1-99213 and 3-99212. We believe these time inputs to be appropriate as the survey results were tightly packed with a high N of 48 and the value is appropriately rank ordered with other codes in this fam
Our IWPUT is .028 which we believe is appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27299

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

Specialty AAOS How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Surgery Frequency 95 Percentage 95.00 %

Specialty Podiatry Frequency 5 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Surgery Frequency 47 Percentage 94.00 %

Specialty Podiatry Frequency 3 Percentage 6.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27768 Tracking Number Y2 Specialty Society Recommended RVU: **5.00**
Global Period: 090 RUC Recommended RVU: **5.00**

CPT Descriptor: Closed treatment of posterior malleolus fracture; with manipulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman presents with ankle pain after a fall. Physical examination and imaging studies demonstrate a [non]displaced fracture of the posterior malleolus. The fracture is reduced by manipulation and casted.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Monitor/assist with patient positioning and padding of bony prominences to allow access of fluoroscopy equipment

Description of Intra-Service Work: The foot, ankle and leg are manipulated and stretched for several minutes by the physician. After careful positioning by the physician, the physician manipulates the fracture until a satisfactory closed treatment is achieved, then holds the foot and a cast is applied from calf to the toes, including applying the paddir While the casting material is setting, the cast is molded to maintain anatomic position of the fracture withc compromising the skin or neurovascular structures.

Description of Post-Service Work: • Assess circulation, sensation and motor function of the extremity
- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Order periodic x-rays
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; William Beach, MD					
Specialty(s):	AAOS/OTA, AOFAS					
CPT Code:	27768					
Sample Size:	200	**Resp N:**	48	**Response:** 24.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**2.00**	5.00	15.00

CPT Code: 27768

Survey RVW:		2.90	4.00	**5.00**	5.63	11.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
re-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		10.00	15.00	**25.00**	30.00	60.00
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in t. following table, and tab through to the new technology/service box.

CPT Code: 27768		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		
Pre-Service Positioning Time:		
Pre-Service Scrub, Dress, Wait Time:		
Intra-Service Time:		
Immediate Post Service-Time:	____	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x 99232x 99233x
Discharge Day Mgmt:	0.0	99238x **0.0** 99239x
Office time/visit(s):	0.0	99211x 12x 13x 14x 15x
Prolonged Services:	0.0	99354x 55x 56x 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27810	090	5.20	**Harvard Time**

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	CPT Code: 27768	Key Reference CPT Code: 27810	Source of Time Harvard Time
Median Pre-Service Time	45.00	34.00	
Median Intra-Service Time	25.00	52.00	
Median Immediate Post-service Time	10.00	11.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	71.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**170.00**	**180.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.38	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.29	2.29
Urgency of medical decision making	2.38	2.24
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.58	2.43
Physical effort required	2.58	2.48
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.46	2.29
utcome depends on the skill and judgment of physician	2.63	2.48
Estimated risk of malpractice suit with poor outcome	2.25	2.48

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.46	2.52
Intra-Service intensity/complexity	2.63	2.57
Post-Service intensity/complexity	2.25	2.24

Additional Rationale

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

The AAOS, OTA and AOFAS convened an expert panel to review the survey results for 27768. We are recommending a work RVU of 5.00 which is the median survey work RVU and we believe appropriately values this service. Our survey respondents choose 27810 as the key reference service and 27810 has a very similar work RVU of 5.20. We believe these two procedures to be very similar in terms of work and intensity; this is confirmed by the surveys results. Our survey respondents indicated a total time for this procedure of 170 minutes distributed as follows: 30 minutes of pre-service evaluation time, 10 minutes of positioning time, 5 minutes of scrub, dress and wait time; 25 intra-service minutes, 10 immediate post service minutes and four post-service office visits, 1-99213 and 3-99212. We believe these time inputs to be appropriate as the survey results were tightly packed v a high N of 48 and the value is appropriately rank ordered with other codes in this family. Our IWPUT is .037 which we beli is appropriate and maintains relativity with the other codes in this family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27899

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

Specialty AAOS How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Surgery Frequency 95 Percentage 95.00 %

Specialty Podiatry Frequency 5 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of Requestor

pecialty Orthopaedic Surgery Frequency 47 Percentage 94.00 %

Specialty Podiatry Frequency 3 Percentage 6.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27769 Tracking Number Y3 Specialty Society Recommended RVU: **10.00**
Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Open treatment of posterior malleolus fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman presents with ankle pain after a fall. Physical examination and imaging studies demonstrate a [non]displaced fracture of the posterior malleolus. An open reduction and internal fixation is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, a posterolateral incision is made. The sural nerve is identified and protected. The interval between the peroneal tendons and the Achilles tendon is developed, retracting these structures. The fracture is identified, cleansed of clot and debris. The fracture is reduced and held with provisional K-wire fixation. Internal fixation is used to buttress the fracture. Position is confirmed with intraoperative radiographs. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
  Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
resenter(s):	R. Dale Blasier, MD; William Creevy, MD; William Beach, MD					
Specialty(s):	AAOS/OTA, AOFAS					
CPT Code:	27769					
Sample Size: 200	**Resp N:** 48	**Response:** 24.0 %				
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**4.00**	6.00	50.00
Survey RVW:		5.90	9.00	**10.00**	12.63	22.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	45.00	**60.00**	61.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
fice time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in t. following table, and tab through to the new technology/service box.

CPT Code: 27769						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	_____					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 38.0 %

TIME ESTIMATES (Median)

	CPT Code: 27769	Key Reference CPT Code: 25607	Source of Time RUC Time
Median Pre-Service Time	75.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	71.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**279.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.80	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.82
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.55	3.41
Physical effort required	3.45	3.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.06
ıtcome depends on the skill and judgment of physician	3.42	3.41
Estimated risk of malpractice suit with poor outcome	2.89	3.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.42	3.24
Post-Service intensity/complexity	2.89	2.73

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The AAOS, OTA and AOFAS convened an expert panel to review the survey results for 27769. We are recommending a work RVU of 10.00 which is the median survey work RVU and we believe appropriately values this service. Our survey respondents choose 25607 as the key reference service and 25607 has a very similar work RVU of 9.35 with similar pre, intra and post-service times as well. We believe these two procedures to be very similar in terms of work and intensity and the surveys results confirm that. Our survey respondents indicated a total time for this procedure of 286 minutes distributed as follows: 45 minutes of pre-service evaluation time, 15 minutes of positioning time, 15 minutes of scrub, dress and wait time; 60 intra-service minutes. 15 immediate post service minutes and four post-service office visits, 2-99213 and 2-99212. We believe these time inputs to appropriate as the survey results were tightly packed with a high N of 48 and the value is appropriately rank ordered with oth codes in this family. Our IWPUT is .057 which believe is appropriate and maintains relativity with the other codes in this family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27899

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

Specialty AAOS How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 50
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Surgery Frequency 47 Percentage 94.00 %

Specialty Podiatry Frequency 3 Percentage 6.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of Reqestor

'pecialty Orthopaedic Surgery Frequency 24 Percentage 96.00 %

Specialty Podiatry Frequency 1 Percentage 4.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Nonfacility and Facility Direct Inputs

CPT Long Descriptor:

27767 Closed treatment of posterior malleolus fracture; without manipulation
27768 Closed treatment of posterior malleolus fracture; with manipulation
27769 Open treatment of posterior malleolus fracture, includes internal fixation, when performed

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 35 (office) and 60 (facility) minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

27767 can be performed in both the office and facility setting. Standard times for the activities necessary in the office and 100% of physician time were applied.

For 27767 and 27768, the standard 6 minutes has been applied for the outpatient procedures for discharge day management services from the facility.

For 27769, the standard 12 minutes has been applied for the inpatient procedure for discharge day management services from the facility.

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E	F	G	H	I
1				27767		27768		27769	
2	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Closed treatment of posterior malleolus fracture; without manipulation		Closed treatment of posterior malleolus fracture; with manipulation		Open treatment of posterior malleolus fracture, includes internal fixation, wh performed	
3	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			90	90	N/A	90	N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	144	183	N/A	183	N/A	189
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	60	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	24	6	N/A	6	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	120	117	N/A	117	N/A	117
9	PRE-SERVICE								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	SERVICE PERIOD								
19	**Start: When patient enters office/facility for surgery/procedure**								
20	**Pre-service services**								
21	Review charts								
22	Greet patient and provide gowning								
23	Obtain vital signs								
24	Provide pre-service education/obtain consent								
25	Prepare room, equipment, supplies			2					
26	Setup scope (non facility setting only)								
27	Prepare and position patient/ monitor patient/ set up IV			2					
28	Sedate/apply anesthesia								
29	**Intra-service**								
30	Assist physician in performing procedure			15					
31	**Post-Service**								
32	Monitor pt. following service/check tubes, monitors, drains								
33	Clean room/equipment by physician staff			3					
34	Clean Scope								
35	Clean Surgical Instrument Package								
36	Complete diagnostic forms, lab & X-ray requisitions								
37	Review/read X-ray, lab, and pathology reports								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptio			2					
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		6		6		12
40	Other Clinical Activity (please specify)								
41	**End: Patient leaves office/FACILITY**								
42	POST-SERVICE Period								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions			3					
45	*Office visits:*								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27	3	3		3		3
49	99213 36 minutes	L037D	36	1	1		1		1
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
53	*Total Office Visit Time*			117	117	0	117	0	117
54	Other Activity (please specify)								
55	**End: with last office visit before end of global period**								
56	MEDICAL SUPPLIES		Unit						
57	pack, minimum multi-specialty visit	SA048	pack	5	4		4		4
58	pack, post-op incision care (suture)	SA054	kit						1
59	drape, sterile, three-quarter sheet	SB014	item	1					
60	gloves, non-sterile	SB022	pair	1					
61	underpad 2ft x 3ft (Chux)	SB044	item	1					
62	Equipment	CMS Code							
63	table, power	EF031	100%	117	117		117		126
64	light, exam	EQ168	100%	117	117		117		126

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Fibula Malunion

At its February 2007 meeting, the CPT Editorial Panel created one new Category I CPT code to describe a service not currently included in CPT for repair of fibula with internal fixation. Current coding fails to address such a procedure when it is not performed with an osteotomy of the fibula or only when the fibula is repaired without open treatment of lateral malleolus.

The RUC reviewed the specialty societies' survey results describing the physician work for CPT code 27726, *Repair of fibula nonunion and/or malunion with internal fixation.* The RUC also reviewed the surveyed service in comparison to the key reference service, CPT code 27709, *Osteotomy; tibia and fibula* (work RVU = 17.32). While the survey data were reliable, the specialty societies and the RUC agreed that the survey median work RVU was too high, as the surveyed service requires less time and is less intense than the reference service. In comparison to the key reference service, the surveyed service contains slightly less intra-service time, 100 minutes versus 108 minutes, respectively. Additionally, the surveyed code requires significantly less complexity and intensity, as survey respondents indicated a lower level of mental effort and judgment, technical skill and physical effort, and psychological stress required to perform the surveyed procedure. The RUC agreed that the number of post-operative hospital visits was appropriate; however, given the differences in intensity to the reference code, reasoned that the intensity of the visits should be lower. The specialty societies agreed and reduced one 99213 visit to one 99212, accounting for a total of three 99212 and one 99213 post-operative office visits. Based on this review, the RUC agreed with the specialty society recommendation of the surveyed 25th percentile work RVU of 14.20 for code 27726.

The RUC recommends the specialty societies' survey 25th percentile work RVU of 14.20 for code 27726.

Practice Expense

The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●27726	Z1	Repair of fibula nonunion and/or malunion with internal fixation (Do not report 27726 in conjunction with 27707)	090	14.20

650

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27726 Tracking Number Z1 Specialty Society Recommended RVU: **14.20**
Global Period: 090 RUC Recommended RVU: **14.20**

CPT Descriptor: Repair of fibula nonunion and/or malunion with internal fixation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female twisted her ankle last winter sustaining sustained a fracture dislocation of her ankle. The patient was treated in a closed manner, without manipulation and with cast immobilization. She presents with ankle pain and a healed fracture which is misaligned. The fibula has healed with shortening and external rotation. An open repair of the fibular malunion is planned using internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
-
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: The leg is elevated and exsanguinated; the pneumatic tourniquet is inflated. An incision is made along the lateral border of the fibula. Dissection is performed, identifying the superficial peroneal nerve and each of the united bone ends. An oblique osteotomy is performed using the micro-oscillating saw, based on preoperative planning. The shape, location and plane of this osteotomy are performed so that restoration of length, rotation and alignment may be achieved. Provisional fixation is performed. Satisfactory restoration of osseous anatomy is confirmed. A neutralization, bridge and/or compression plating is/are performed using anatomically contoured implants while avoiding both the ankle joint and the distal tibial-fibula syndesmosis. The osseous correction and the position of the implants are monitored throughout the procedure with fluoroscopy. The wound is irrigated and closed in layers. Permanent radiographs are obtained and reviewed.

escription of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Creevy, MD; William Beach, MD				
Specialty(s):	AAOS/OTA, AOFAS				
CPT Code:	27726				
Sample Size: 200	**Resp N:** 34	**Response:** 17.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**3.00**	5.00	10.00
Survey RVW:	10.00	14.20	**15.50**	19.00	20.00
Pre-Service Evaluation Time:			**40.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	60.00	90.00	**100.00**	120.00	150.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**			
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 27726		
		Specialty Recommended
Physician Work RVU:		14.20
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		100.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	71.0	99211x 0.0 12x 3.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27709	090	17.32	RUC Time

CPT Descriptor Osteotomy; tibia and fibula

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 26.4 %

TIME ESTIMATES (Median)

	CPT Code: 27726	Key Reference CPT Code: 27709	Source of Time RUC Time
Median Pre-Service Time	70.00	68.00	
Median Intra-Service Time	100.00	108.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	71.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**319.00**	**347.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	3.63
Urgency of medical decision making	2.00	2.25

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	4.00
Physical effort required	3.00	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.75
Outcome depends on the skill and judgment of physician	3.89	4.00
Estimated risk of malpractice suit with poor outcome	3.00	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	3.63
Intra-Service intensity/complexity	3.63	4.00
Post-Service intensity/complexity	2.25	2.86

Additional Rationale

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

The AAOS and AAHKS, along with OTA convened an expert panel to review the survey results for 27726. We are recommending a work RVU of 14.20 which is the 25% survey result. Our key comparison service was 27709, with a work RVU of 17.32, intra-service time of 108 minutes, two post-operative hospital visit days plus one discharge day, and four total post-operative office visit days with 2-99213 and 2-99212. The total time for our comparison code 27236 is 347. Our total time for our survey code is very similar at 326 minutes, distributed as follows: 40 minutes evaluation time, 15 minutes for positioning and 15 minutes for scrub, dress and wait time; 100 minutes for intra-service time; 20 minutes for immediate post-service time; one 99231 hospital visit, one 99238 discharge day; and four total post-operative office visits, 2-99213 and 2-99212. We felt the survey median RVU for 27726 of 15.50 was slightly higher than we believed was appropriate and we believe the 25th percentile work RVU of 14.20 is the more appropriate and correct value. A RVU of 14.20 produces an IWPUT of .076 which we believe is an appropriate approximation of the intensity for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) (27792 + 27707) or 27899

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

Specialty AAOS How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Frequency 100 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Frequency 50 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

27726: Repair of fibula nonunion and/or malunion with internal fixation

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 35 (office) and 60 (facility) minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

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

The standard 6 minutes has been applied for the outpatient procedures for discharge day management services from the facility.

The standard 12 minutes has been applied for the inpatient procedure for discharge day management services from the facility.

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E
1				27726	
2	April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Repair of fibula nonunion and/or malunion with internal fixation	
3	LOCATION	Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	183
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	117
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	SERVICE PERIOD				
19	**Start: When patient enters office/facility for surgery/procedure**				
20	**Pre-service services**				
21	Review charts				
22	Greet patient and provide gowning				
23	Obtain vital signs				
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies				
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV				
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure				
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff				
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		6
40	Other Clinical Activity (please specify)				
41	**End: Patient leaves office/FACILITY**				
42	POST-SERVICE Period				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
45	*Office visits:*				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes	L037D	27		3
49	99213 36 minutes	L037D	36		1
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	*Total Office Visit Time*			0	117
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				
55	MEDICAL SUPPLIES		Unit		
56	pack, minimum multi-specialty visit	SA048	pack		4
57	pack, post-op incision care (suture)	SA054	kit		
58	drape, sterile, three-quarter sheet	SB014	item		
59	gloves, non-sterile	SB022	pair		
60	underpad 2ft x 3ft (Chux)	SB044	item		
61	Equipment	CMS Code			
62	table, power	EF031			117
63	light, exam	EQ168			117

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Internal or External Fixation-Foot/Ankle

As part of the 2005 Five Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2007 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty that these codes needed to be clarified and removed reference to external fixation from 64 CPT codes. These 64 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. The Hip/Knee codes will be discussed at the April 2007 RUC Meeting.

Between 225 and 450 orthopaedic providers participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, foot and ankle surgery, orthopaedic trauma surgery and podiatry. After the results from all of these groups were tablulated, a concensus committee of physicians representing the American Academy of Orthopaedic Surgeons, Arthroscopy Association of North America, Orthopaedic Trauama Association, American Podiatic Medical Association and the American Orthopaedic Foot and Ankle Society met to discuss the survey data for the revised orthopaedic codes. During this review, the specialties determined that they would recommend the 25th percentile for codes in situations where all of the fracture codes, when they were arrayed in order of complexity, it was rational to recommend the 25th percentile RVU value as a means to maintain rank order. Furthermore, the specialty

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societies reviewed the resulting IWPUTs associated with the revised codes and determined that these IWPUT values validated the recommended work RVUs.

The RUC reviewed the compelling evidence for these procedures. The specialty societies claimed that because the CPT descriptors originally contained the phrase "with or without internal or external fixation," it is difficult to imagine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs.

Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. There are also new internal fixation devices which require more work. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. Also, for several of the identified procedures, the provider of the services have changed and were not a part of the original Harvard studies such as the American Podiatric Medical Association. The RUC agreed that there was an abundant amount of compelling evidence to review these codes with the exception of CPT codes 27822 *Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip* (Work RVU=12.12), 27823 *Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip* (Work RVU=14.26) and 28445 *Open treatment of talus fracture, includes internal fixation, when performed* (Work RVU=17.07). These three identified codes were not reviewed by the RUC because the RUC agreed that the nature of the work involved in providing these services has not substantially changed since the RUC last reviewed them in 2000. The specialty societies conducted a full RUC survey of all codes, and for almost all of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending a slight reduction in work RVUs for one code in this family, 27766 and maintaing the work RVUs for four codes, 27822, 27823, 28445 and 28415.

The RUC thoroughly reviewed these codes, and as part of this review, the specialties explained that they felt strongly that a 99214 office visit was appropriate for two of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99213 office visit. The RUC reviewed CPT code 20690 *Application of a uniplane (pins or wires in*

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one plane), unilateral, external fixation system and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)*. It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲27766	F44	Open treatment of medial malleolus fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	8.50
▲27784	F45	Open treatment of proximal fibula or shaft fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	10.45
▲27792	F46	Open treatment of distal fibular fracture (lateral malleolus), ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	10.50
▲27814	F47	Open treatment of bimalleolar ankle fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	11.50
▲27822	F48	Open treatment of trimalleolar ankle fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	090	12.12 (No Change)
▲27823	F49	Open treatment of trimalleolar ankle fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed medial and/or lateral malleolus; with fixation of posterior lip	090	14.26 (No Change)
▲27826	F50	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal ~~or external~~ fixation, when performed; of fibula only	090	12.00
▲27827	F51	Open treatment of fracture of weight bearing articular surface/portion of distal tibia	090	16.00

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		(eg, pilon or tibial plafond), with internal ~~or external~~ fixation, when performed; of tibia only		
▲27828	F52	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal ~~or external~~ fixation, when performed; of both tibia and fibula	090	20.00
▲27829	F53	Open treatment of distal tibiofibular joint (syndesmosis) disruption, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	9.50
▲27832	F54	Open treatment of proximal tibiofibular joint dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, or with excision of proximal fibula	090	11.00
▲28415	F55	Open treatment of calcaneal fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed;	090	17.54 (No Change)
▲28420	F56	Open treatment of calcaneal fracture, ~~with or without~~ includes internal ~~or external~~ fixation when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	090	19.00
▲28445	F57	Open treatment of talus fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	17.07 (No Change)
▲28465	F58	Open treatment of tarsal bone fracture (except talus and calcaneus), ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each	090	9.50
▲28485	F59	Open treatment of metatarsal fracture, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each	090	8.00
▲28505	F60	Open treatment of fracture great toe, phalanx or phalanges, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	8.00
▲28525	F61	Open treatment of fracture, phalanx or phalanges, other than great toe, ~~with or without~~ includes internal ~~or external~~ fixation, when performed, each	090	6.00

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▲28555	F62	Open treatment of tarsal bone dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	10.43
▲28585	F63	Open treatment of talotarsal joint dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	12.00
▲28615	F64	Open treatment of tarsometatarsal joint dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	11.50
▲28645	F65	Open treatment of metatarsophalangeal joint dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	8.00
▲28675	F66	Open treatment of interphalangeal joint dislocation, ~~with or without~~ includes internal ~~or external~~ fixation, when performed	090	6.00

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AMA/Specialty Society RVS Update Committee
RUC Recommendations - Internal or External Fixation
CPT Code Order

CPT Code	*Descriptor*	*Global*	*RUC Rec Work RVU*	*RUC Rationale*
23515	Open treatment of clavicular fracture, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 23515 Open treatment of clavicular fracture, includes internal fixation, when performed and compared it to its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC compared the intra-service times for these procedures and noted that 23515 had less intra-service time associated with it as compared to 29827, 90 and 120 minutes, respectively. The RUC compared the intensity complexity measures of 23515 amd 29827 and noted that the reference code required more technical skill to perform and had a more intense intra-service period as compared to 23515. Therefore, the RUC agreed that the median of the survey data, 11.00 RVUs, appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 23515 as 28299 has slightly more total service time associated with it in comparison to 23515, 299 minutes and 287 minutes respectively. The RUC recommends 11.00 RVUs for 23515.
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation	090	16.25	The RUC reviewed CPTcode 23585 Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation and compared it to its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC noted that the total service time for the surveyed code was lower than the reference code, 407 minutes and 469 minutes respectively. Furthermore, the RUC compared the intensities of these procedures and determined that because, 23585 is one of the most complex of the procedures performed for reduction and internal fixation of shoulder fractures and typically requires an extensive exposure of the scapula with significant muscle disection and identification and protection of the suprascapular nerve and artery, it was deemed a more intensive procedure than the reference code 27447. However, the RUC agreed that to keep this code in proper rank order with other codes in the family, such as 23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed (RUC recommended value of 15.00 RVUs) and 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement (RUC recommended value of 21.00 RVUs), the value associated with this procedure should be the 25th percentile of the survey, 16.25 RVUs. The RUC recommends 16.25 RVUs for 23585.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	090	14.00	The RUC reviewed CPT code 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; and compared it with its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC noted that the surveyed code has significantly less intra-service time associated with it as compared to the reference code, 90 minutes and 130 minutes, respectively. Further, the RUC noted that the reference service required more physical effort to perform and has a more complex intra-service period as compared to 23615. The RUC reviewed several other codes under review in this family, such as 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed (RUC Recommended value=14.00 RVUs) 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna (RUC recommended value=14.00). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the 25th percentile of the survey, 14.00 RVU appropriately places this service in comparison to 23670, 25575 and the key reference service 29827. The RUC recommends 14.00 RVU for 23615.
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement	090	21.00	The RUC reviewed CPT code 23616 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s) , when performed; with proximal humeral prosthetic replacement and compared it with its reference code 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (Work RVU=22.47). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. The RUC noted that 23616 has less intra-service time associated with it as compared to the reference code, 120 minutes and 165 minutes, respectively. Although 23472 has longer intra-service times than the surveyed code, with 23616 comminution is frequently present which makes correct positioning of the prosthesis and stable repair of the tuberosity fragments difficult this makes 23616 a very intensive procedure to perform. For further support the RUC reviewed MPC code 50546 Laparoscopy, surgical; nephrectomy, including partial ureterectomy (Work RVU=21.69). The RUC noted that 50546 had a longer intra-service time in comparison to 23616, 205 minutes and 120 minutes, respectively. Therefore, the RUC agreed that the median value of 21.00 RVUs is appropriate and correctly places this code in comparison to the reference code, 23472 and 50546. The RUC noted that the proposed value for this procedure, 21.00 RVUs, is less than the existing value, 21.68 RVUs. The RUC recommends 21.00 RVUs for 23616.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	090	12.00	The RUC reviewed CPT code 23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed and compared it to its reference code 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) (Work RVU=14.75). The RUC noted that the intra-service time of the surveyed code was far less than the intra-service time of the reference code, 70 minutes and 120 minutes. The RUC also noted that although 23630 is a shoulder fracture that commonly occurs in tandem with poor bone quality, making fixation of the fragment difficult and tenuous, the reference code is a more intensive procedure to perform. This comparison of intensity is demonstrated in the intensity measure of the intra-service time associated with the surveyed code, as it is less than the intensity associated with the reference code. Therefore, the RUC recommends the 25th percentile of the survey for this procedure, 12.00 RVUs. For further support, the RUC compared 23630 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 23630 has less intra-service time as compared to 60220, 70 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 23420. The RUC recommends 12.00 RVU for 23630.
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	090	14.00	The RUC reviewed CPT code 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed and compared it with its reference code 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) (Work RVU=14.75). The RUC noted that the surveyed code has significantly less intra-service time associated with it as compared to the reference code, 90 minutes and 120 minutes, respectively. However, all of the intensity and complexity measures demonstrated that the surveyed code was significanly more difficult to perform than the reference code. The RUC reviewed several other codes under review in this family, such as 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (RUC recommended value of 14.00 RVUs) and 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna (RUC recommended value of 14.00 RVUs). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the 25th percentile of the survey, 14.00 RVU appropriately places this service in comparison to 23615, 25575 and the key reference service 23420. The RUC recommends 14.00 RVU for 23670.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	090	15.00	The RUC reviewed CPT code 23680 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed and compared it to its reference code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU=15.44). The RUC noted that 23680 and 29827 have the same pre-service time (75 minutes) and intra-service time (120 minutes). The RUC agreed that that in addition to the times for these two procedures being the same that the complexity and work associated with them is similar as well. Therefore the RUC recommends the 25th percentile of the survey 15.00 RVUs to reflect this similarity in service times and work. The RUC recommends 15.00 RVUs for 23680.
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	090	15.00	The RUC reviewed CPT code 24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC reviewed the total-service times for both codes and found them to be comparable, 361 minutes and 358 minutes. However, the RUC noted that the intensity/complexity measures for 24545 were significantly higher in comparison to 25609 as the complexity and risk for complication involved in 24545 is much greater than 25609. Therefore the RUC agreed that the median value of 15.00 RVU appropriately places this code in comparison to the reference code. The RUC recommends a work RVU of 15.00 for code 24545.
24546	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	090	17.01	The RUC reviewed CPT code 24546 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension and compared it with its reference code 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (Work RVU=22.47). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and a 99212 office visit being associated with this procedure. However, after comparing 24546 with 23472, the RUC determined that this reference code was not a suitable comparison. The RUC agreed that the better reference code would be 24545 Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension (RUC recommended RVU=15.00 RVUs). The RUC compared the total service times for both procedures and determined at 24546 had a longer intra service time in comparison to 24545, 150 minutes and 120 minutes. The RUC also agreed that the intensity/complexity of performing 24546 is significantly higher that performing 24545 as 24545 is an extra-articular fracture and 24546 is an intra-articular fracture requiring extensive exposure of the joint. Therefore, to calculate the recommended RVUs for this procedure, the RUC started with the 25th percentile of the survey data, 16.34 RVUs and added a work RVU increment of 2.01, the difference in intra-service times between 24546 and 24545 (30 minutes) multiplied by the IWPUT of 24545 (0.067). This calculation results in a value of 17.01 RVUs. The RUC recommends 17.01 RVUs for 24546.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 305 minutes and 308 minutes. Therefore the RUC agreed that the median value of 11.00 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 24575 as 28299 has more intra- service time associated with it in comparison to 24575, 90 minutes and 60 minutes, respectively. The RUC noted that the proposed value for this procedure, 11.00 RVUs, is slightly less than the existing value, 11.02 RVUs. The RUC recommends 11.00 RVUs for 24575.
24579	Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	090	13.00	The RUC reviewed CPT code 24579 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed and compared it to 25609 Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed (Work RVU=14.12). The RUC noted that the intra-service time for the surveyed code is significantly less than the reference code, 90 minutes and 120 minutes. Furthermore, the RUC noted that the reference code requires more mental effort and judgement and technical skill to perform in comparison to 24579. Because of a lower intra-service time and lower intensity and complexity measures of the surveyed code in comparison to the reference code, the RUC recommends the survey median work RVU, 13.00 RVUs for 24579 as it appropriately places this code in comparison to the reference code. For further support the RUC compared 24579 to 24575 Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed (RUC recommended value=11.00 RVU). The RUC noted that these procedures are similar except 24579 has the addition of an intraarticular extension involving the entire condylar structure. The same neurovascular structures are at risk in 24579 and 24575 except 24579 has the added complexity of obtaining and holding the articular surface reduced anatomically to maintain joint congruity. Because of these comparisons to a reference code and another code within the family, the RUC recommends 13.00 RVUs for 24579.

670

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	090	10.00	The RUC reviewed CPT code 24635 Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the total service time for 24635 is higher than the total service time for 25607, 291 minutes and 275 minutes, respectively. Furthermore, the work for 24635 is greater than 25607 because the dislocated radial head must be treated in addition to the ulna fracture and post-operatively there is a danger of neurovascular injury and compartment syndrome. Close monitoring is required. This is demonstrated in the intensity/complexity measures which indicate that the surveyed code requies greater mental effort and judgement, greater technical skill and greater physical effort to perform in comparison to the reference code. Furthermore, the RUC noted that this service requires a hospital stay as there is significant monitoring of circulation, sensation and motor function of the involved extremity. Therefore, the RUC agreed that the 25th percentile of the survey data, 10.00 work RVUs accurately places this code in comparison to the reference code. The RUC noted that the proposed value for this procedure, 10.00 RVUs, is less than the existing value, 13.56 RVUs. The RUC recommends 10.00 work RVUs for 24635.
24685	Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed	090	9.50	The RUC reviewed CPT code 24685 Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that while both services have an intra-service time of 60 minutes, the surveyed procedure is more complex than the reference code as 24685 is intraarticular and 25607 is extraarticular. This complexity of the intra-service is also noted in the intra-service intensity complexity measure which shows that the surveyed code's intra-service period is more intense than the intra-service time associated with the reference code. Furthermore, the intensity/complexity measures indicate that the surveyed code requires greater mental effort and judgment, greater technical skill and greater physical effort to perform in comparison to the reference code. Therefore, the RUC agreed that the 25th percentile of the survey data, 9.50 work RVUs, accurately places this code in comparsion to the reference code. The RUC recommends 9.50 work RVUs for 24685.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed	090	10.00	The RUC reviewed CPT code 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, physical effort, mental effort and judgment to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 10.00 work RVU appropriately places 25515 in comparison to the reference code. The RUC recommends 10.00 work RVUs for 25515.
25525	Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed	090	12.00	The RUC reviewed CPT code 25525 Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. With this change, the RUC noted that the total service times for both of these codes are comparable, 303 minutes and 305 minutes. However, the RUC noted that the surveyed code required greater mental effort and judgment and physicial effort to perform in comparison to the reference code. Therefore, due to comparable total service times but greater intensity/complexity measures, the RUC recommends the survey median, 12.00 RVU for this procedure. For further support, the RUC compared 25525 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 25525 has less intra-service time as compared to 60220, 70 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 25608. The RUC noted that the proposed value for this procedure, 12.00 RVUs, is less than the existing value, 12.69 RVUs. The RUC recommends 12.00 RVU for 22525.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25526	Open treatment of radial shaft fracture, with internal fixation, when performed, and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	090	15.00	The RUC reviewed CPT code 25526 Open treatment of radial shaft fracture, with internal fixation, when performed, and open treatment of distal radioulnar joint, with internal fixation, when performed (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments. The RUC agreed that the specialty society recommended 99214 office visit should be removed and two 99212 office visit should be added as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in two 99213 office visits and three 99212 office visits being associated with this procedure. With these changes, the RUC noted that the surveyed code has more total service time associated with it in comparison to the reference code, 398 minutes and 358 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgement and more physical effort to perform and has a more complex intra-service period as compared to 25609. The difficulty of this procedure can be explained as this is the most complex of the hand procedures reviewed because this procedure consists of two separate procedures, an open reduction internal fixation of the radius which places the radial nerve in danger as well as the radial artery and a separate arthrotomy of the ulnocarpal joint and repair of the triangular fibrocartilage complex. Because of the increased total service time as well as the higher intensity/complexity measures associated with 25526 in comparison to its reference code, the RUC recommends the survey median of 15.00 work RVU for 25526. The RUC recommends 15.00 RVUs for 25526.
25545	Open treatment of ulnar shaft fracture, includes internal fixation, when performed	090	9.00	The RUC reviewed CPT code 25545 Open treatment of ulnar shaft fracture, includes internal fixation, when performed in compairison to 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the surveyed code and the reference code had the same intra-service time, 60 minutes. The RUC noted that 25545 requires a 99231 hospital visit as there is a danger of neurovascular injury and compartment syndrome and close monitoring is needed. The RUC also noted that the reference code requires greater endurance of psychological stress to perform as compared to the surveyed code. The RUC compared this procedure to 26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed (RUC recommended value of 9.00 RVUs) and MPC code 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less (Work RVU=9.07 and noted that because all of these procedures had similar work and the same intra-service time, 60 minutes, that they should all be valued the similarly. Therefore, because of all of these comparisons, the RUC recommends the median survey RVU, 9.00 work RVUs. The RUC noted that the proposed value for this procedure, 9.00 RVUs, is less than the existing value, 9.09 RVUs. The RUC recommends 9.00 Work RVUs for 25545.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25574	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	090	10.00	The RUC reviewed CPT code 25574 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, mental effort and judgement to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 10.00 work RVU appropriately places 25574 in comparison to the reference code. The RUC recommends 10.00 work RVUs for 25574.
25575	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	090	14.00	The RUC reviewed CPT code 25575 Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna and compared it with its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC agreed that the specialty society recommended 99214 office visit should be removed and two 99212 office visit should be added as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in two 99213 office visits and three 99212 office visits being associated with this procedure. With these changes, the RUC noted that the surveyed code has less total service time associated with it in comparison to the reference code, 342 minutes and 358 minutes, respectively. Further, the RUC noted that the reference service required more technical skill, physical effort and more psychological stress to perform and has a more complex intra-service period as compared to 25609. The RUC reviewed several other codes under review in this family, such as 23670 Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed (RUC Recommended wRVU=14.00 RVUs) 23615 Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; (RUC recommended wRVU=14.00). The RUC determined that because all of these services had the same intra-servce time, 90 minutes and because they all involve similar complexity and intensity to perform the service, the RUC agreed that the median of the survey, 14.00 RVUs appropriately places this service in comparison to 23670, 23615 and the key reference service 25609. The RUC recommends 14.00 RVUs for 25575.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed	090	11.00	The RUC reviewed CPT code 25628 Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed and compared it with its reference code 25394 Osteoplasty, carpal bone, shortening (work RVU=10.71). The RUC noted that the total service time for the surveyed code is more than the total service time for the reference code (277 minutes and 250 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the surveyed code required more technical skill, physical and mental effort and judgement to perform than the reference code. With the higher amount of total service time and higher intensity/complexity measures as compared to 25394, the RUC agreed that the 25th percentile of survey, 11.00 work RVU appropriately places 25628 in comparison to the reference code. The RUC recommends 11.00 work RVUs for 25628.
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	090	8.00	The RUC reviewed CPT code 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (work RVU=9.35). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more mental effort and judgement and more psychological stress. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25607, the RUC agreed that the 25th percentile of survey, 8.00 work RVU appropriately places 26615 in comparison to the reference code. The RUC recommends 8.00 work RVUs for 26615.
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with external fixation	090	6.00	The RUC reviewed CPT code 26650 Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with external fixation and compared it to its reference code 25651 Percutaneous skeletal fixation of ulnar styloid fracture (work RVU=5.68). The RUC compared the total service times for these procedures and noted that the surveyed code (197 minutes of total service time) had more total service time associated with it than the 25651 (190 minutes of total service time). The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25651 has one 99213 and three 99212 associated with it, which suggests the surveyed code involves more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/complexity measures which show that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. Therefore, because of the greater total service time and the more intense post-operative visits, the RUC agreed that the median RVU of the survey data appropriately places 26650 in comparison to 25651. The RUC recommends 6.00 RVUs for 26650.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed	090	9.00	The RUC reviewed CPT code 26665 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed in comparison to 25652 Open treatment of ulnar styloid fracture (Work RVU=7.92). The RUC noted that the surveyed code had a greater total service time associated with it in comparison to the reference code, 237 minutes and 225 minutes, respectively. The RUC also noted that the surveyed procedure requires greater physicial effort and an endurance of greater psychological stress to perform as compared to the reference code. Furthermore, the surveyed code is a more complex procedure to perform than the reference code given the increased intensity of dealing with an intraarticular fracture as demonstrated in the intensity/complexity time measures which shows that surveyed code is a much more intense procedure to perform than the reference code. The RUC agreed that because of the larger total service time and the greater amount of intensity and complexity associated with the surveyed code as compared to the reference code, the RUC recommends the median survey RVU, 9.00 work RVUs. In addition, the RUC agreed this value is appropriate because it has similar work and the same intra-service time as MPC code 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less (Work RVU=9.07). The RUC recommends 9.00 Work RVUs for 26665.
26685	Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint	090	8.00	The RUC reviewed CPT code 26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service times for both procedures are 60 minutes. The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25652 has one 99213 and three 99212 associated with it which suggests the surveyed code has a more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/ complexity measure which shows that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. With the same amount of intra-service time and slightly different office visits as compared to 25652, the RUC agreed that the median of the survey, 8.00 work RVUs appropriately places 26685 in comparison to the reference code, 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone and 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed which all have the same complexity and proposed work RVU. The RUC recommends 8.00 work RVUs for 26685.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	090	7.95	The RUC reviewed CPT code 26715 Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed and compared it to its reference code, 25671 Percutaneous skeletal fixation of distal radioulnar dislocation (Work RVU=6.32). The RUC compared the total service times for these procedures and noted that the surveyed code (220 minutes of total service time) had more total service time associated with it than the 25671 (210 minutes of total service time). The RUC also compared the office visits associated with this procedure and noted that although they both have four post-operative office visits associated with them, the surveyed code has two 99213 and two 99212 visits associated with it while 25651 has one 99213 and three 99212 associated with it which suggests the surveyed code involves more complex post operative care as compared to the reference code. This difference in the intensity of the post-operative care is also demonstrated in the post-operative intensity/ complexity measure which shows that the post service time segment of the surveyed code has a greater intensity associated with it as compared to the reference code. Therefore, because of the greater total service time and the more intense post-operative visits, the RUC agreed that the median RVU of the survey data 7.95 work RVUs, appropriately places 26715 in comparison to 25671. Furthermore, the RUC agreed that this value correctly places this procedure in terms of complexity in comparison to other orthopaedic codes such that it is more complex than 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single (RUC recommended work RVU =7.45 work RVU) and has similar complexity to 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC recommended work RVU=8.00). The RUC recommends 7.95 RVUs for 26715.
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	090	8.40	The RUC reviewed CPT code 26735 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more physical effort and more psychological stress to perform than the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25608, the RUC agreed that the 25th percentile of survey, 8.40 work RVUs appropriately places 26735 in comparison to the reference code. Furthermore, the RUC compared the surveyed code with MPC code 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (Work RVU=8.44) and agreed that 8.40 RVU was an approriate value for the surveyed code because the surveyed code had similar total-service time as compared to this procedure, 237 minutes and 223 minutes, respectively. The RUC recommends 8.40 work RVUs for 26735.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	090	11.10	The RUC reviewed CPT code 26746 Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 303 minutes and 305 minutes. However, the RUC noted that the intensity/complexity measures for 26746 were significantly higher in comparison to 25608 as the complexity and risk for complication involved in 26746 is much greater than 25608. Therefore the RUC agreed that the median value of 11.10 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.10 work RVUs was appropriate for 26746 as 28299 has more intra- service time associated with it in comparison to 27832, 90 minutes and 83 minutes respectively. The RUC recommends 11.10 RVUs for 26746.
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	090	6.60	The RUC reviewed CPT code 26765 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical effort, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25652, the RUC agreed that the 25th percentile of survey, 6.60 work RVU appropriately places 26765 in comparison to the reference code. The RUC recommends 6.60 work RVUs for 26765.
26785	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single	090	7.45	The RUC reviewed CPT code 26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single and compared it with its reference code 25652 Open treatment of ulnar styloid fracture (work RVU=7.92). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical effort, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25652, the RUC agreed that the 25th percentile of survey, 7.45 work RVU appropriately places 26785 in comparison to the reference code. The RUC recommends 7.45 work RVUs for 26785.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	090	8.50	The RUC reviewed CPT code 27766 Open treatment of medial malleolus fracture, includes internal fixation, when performed and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (work RVU=9.35). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The RUC noted that this procedure requires a 99231 hospital stay because of the risk of post-operative complications. The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical skill, physical effort and more psychological stress to perform than the reference code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 25607, the RUC agreed that the 25th percentile of survey, 8.50 work RVU appropriately places 27766 in comparison to the reference code. The RUC noted that the proposed value for this procedure, 8.50 RVUs, is less than the existing value, 8.73 RVUs. The RUC recommends 8.50 work RVUs for 27766.
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	10.45	The RUC reviewed CPT code 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed and compared it with its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation (Work RVU=9.35). The RUC noted that the total service time of 27784 is higher than the total service time of the reference code, 281 minutes and 275 minutes, respectively. The RUC reviewed the intensity complexity measures associated with 27784 and 25607. The RUC noted that 27784 requires more technical skill, physical effort and psychological stress to perform than the reference code. With the higher amount of total service time of the surveyed code in comparison to the reference code and the higher intensity/complexity measures of the surveyed code in comparison to the reference code, the RUC agreed that the median of the survey, 10.45 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.45 RVU for 27784 was appropriate as the intra-service time for 27784 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.45 RVUs for 27784.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	090	10.50	The RUC reviewed CPT code 27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the intra-service time of 27792 is significantly less than the intra-service time of the reference code, 60 minutes and 90 minutes, respectively. The RUC also noted that the care for this type of fracture is slightly more complex than 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed (RUC Recommended Value=10.45). With the lower amount of intra-service time of the surveyed code in comparison to the reference code and maintaining the proper rank order between the surveyed code and 27784, the RUC agreed that the median of the survey, 10.50 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.50 RVU for 27792 was appropriate as the intra-service time for 27792 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.50 RVUs for 27792.
27814	Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed	090	11.50	The RUC reviewed CPT code 27814 Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC compared the intra-service times for these procedures and noted that 27814 had less intra-service time associated with it as compared to 25609, 90 and 120 minutes, respectively. The RUC compared the intensity complexity measures of 27814 amd 25609 and noted that the reference code required more physical effort, mental effort and judgement to perform as compared to 23515. Therefore, the RUC agreed that the 25th percentile of the survey data, 11.50 RVUs, appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.50 work RVUs was appropriate for 27814 as 28299 has the less total service time than the 27814, 299 minutes and 346 minutes respectively. The RUC recommends 11.50 RVUs for 27814.
27822	Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	090	12.12	The RUC reviewed CPT code 27822 Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed since the RUC last reviewed it in 2000. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 27822 be maintained at its current value, 12.12.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27823	Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	090	14.26	The RUC reviewed CPT code 27823 Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed since the RUC last reviewed it in 2000. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 27823 be maintained at its current value, 14.26 RVUs.
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	12.00	The RUC reviewed CPT code 27826 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only and compared it to its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and one 99212 office visits being associated with this procedure. The RUC noted that the intra-service time of the surveyed code was far less than the intra-service time of the reference code, 60 minutes and 120 minutes. The RUC compared the intensity/complexity mesaures for these procedures and noted that they were comparable. The RUC after revieweing these times and complexity measures associated with the key reference code and the surveyed code agreed that this surveyed code has the same amount of complexity and work as 25525 Open treatment of radial shaft fracture, with internal fixation, when performed, and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with percutaneous skeletal fixation, when performed, 23630 Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed and 25585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed and therefore recommends that this procedure be valued the same as these other reference codes (all three codes RUC recommended RVU=12.00). The RUC recommends 12.00 RVUs for 27826. For further support, the RUC compared 27826 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 27826 has less intra-service time as compared to 60220, 60 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the key reference code, 25609. The RUC recommends 12.00 RVU for 27826.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	090	16.00	The RUC reviewed CPT code 27827 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 27827 with 27447, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed and the RUC recommended that its value be maintained, could now be used as an alternative reference code. The RUC compared the total service times for both procedures and determined at 28445 had a longer total service time in comparison to the surveyed code 485 minutes and 458 minutes. In addition, the RUC agreed that the intensity and complexity of performing 28445 would be greater than performing 27827. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 16.00 RVUs for 27827.
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	090	20.00	The RUC reviewed CPT code 27828 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 27828 with 27447, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed, could now be used as an alternative reference code. The RUC compared the intra-service times for both procedures and determined at 27828 had a longer intra-service time in comparison to the reference code, 150 minutes and 125 minutes. In addition, the RUC agreed that the intensity and complexity of performing 27828 would be greater than performing 28445. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 20.00 RVUs for 27828.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	9.50	The RUC reviewed CPT code 27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed and compared it to its reference code 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation. The RUC noted that although the reference code has more intra-service time compared with it than the reference code, 60 minutes and 45 minutes, respectively, that the surveyed code has more pre-service time associated with it as more time is required in 27829 to evaluate the fracture. The intensity and risk for complication involved in treating the distal tibia fracture is much greater than the intensity and risk for complication involved with 25607. This is demonstrated in the intensity/comlexity measures which demonstrates that 27829 requires more mental effort and judgement, more technical skill and physical effort and is an overall more intense code to perform than 25607. In addition, the surveyed code has more post-operative work in comparison to 25607, because 27829 requires hospitialization to avoid skin issues, swelling and to assess neurocirculatory status. Because of the greater amount of intensity as well as the hospitalization associated with this service, the RUC agreed the 25th percentile of the survey, 9.50 RVUs accurately places this procedure in comparison to the reference code. The RUC recommends 9.50 RVUs for 27829.
27832	Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	090	11.00	The RUC reviewed CPT code 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula and compared it to its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC reviewed the total-service times for both codes and found them to be comparable, 301 minutes and 305 minutes. However, the RUC noted that the intensity/complexity measures for 27832 were significantly higher in comparison to 25608 as the complexity and risk for complication involved in open treatment of the trimalleolar ankle fracture is much greater than 25608. Therefore the RUC agreed that the median value of 11.00 RVU appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to MPC code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39) and determined that 11.00 work RVUs was appropriate for 27832 as 28299 has more intra- service time associated with it in comparison to 27832, 90 minutes and 75 minutes respectively. The RUC recommends 11.00 RVUs for 27832.
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	090	17.54	The RUC reviewed CPT code 28415 Open treatment of calcaneal fracture, includes internal fixation and recommended that a 99214 office visit should be removed and substituted with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. The RUC agreed that the new survey time data for this procedure further validated the existing work RVUs for this procedure and recommend maintaing the value for this code. The RUC recommends that the new surveyed times be applied to this code and maintaining the current work of 17.54 RVUs for 28415.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	090	19.00	The RUC reviewed CPT code 28420 Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft) and compared it with its reference code 27487 Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component (Work RVU=26.91). The RUC agreed that the specialty society recommended 99214 office visit should be removed and replaced with a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in four 99213 office visits and one 99212 office visits being associated with this procedure. However, after comparing 28420 with 27847, the RUC determined that this reference code was not a suitable comparison after the determination was made that 28445 Open treatment of talus fracture, with or without internal or external fixation (Work RVU=17.07), originally part of this internal/external fixation review had no compelling evidence to be reviewed, could now be used as an alternative reference code as the RUC recommended that the value for this service be maintained at its existing value. The RUC compared the intra-service times for both procedures and determined at 28420 had a longer intra-service time in comparison to the reference code, 150 minutes and 125 minutes. In addition, the RUC agreed that the intensity and complexity of performing 28420 would be greater than performing 28445. Therefore, the RUC agrees that the 25th percentile of the survey data accurately places this code in comparison to the reference code 28445. The RUC recommends 19.00 RVUs for 28420.
28445	Open treatment of talus fracture, includes internal fixation, when performed	090	17.07	The RUC reviewed CPT code 28445 Open treatment of talus fracture, includes internal fixation, when performed and agreed that there was not compelling evidence to review it because the nature of the work involved in providing this service has not substantially changed. The RUC recommends that the new surveyed times be applied to this code and that the work RVUs for 28445 be maintained at its current value, 17.07 RVUs.

684

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	090	9.50	The RUC reviewed CPT code 28465 Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each and compared it with its reference code 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU=10.86). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). In addition, the number of post-operative visits is not the same as the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with three 99213 office visits and two 99212, which suggests the surveyed code involves less complex post operative care as compared to the reference code. However, the RUC also compared this procedure to 24685 Open treatment of ulnar fracture proximal end (olecranon process), includes internal fixation, when performed (RUC recommended work RVU=9.50) and 27829 Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed (RUC Recommended work RVU=9.50). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as compared to 25608, the RUC agreed that 9.50 work RVU appropriately places 28465 in comparison to 25608, 24685 and 27829. The RUC recommends 9.50 work RVUs for 28465.
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	090	8.00	The RUC reviewed CPT code 28485 Open treatment of metatarsal fracture, includes internal fixation, when performed, each and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (60 minutes and 90 minutes, respectively). The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with three 99213 office visits and one 99212 office visit, which suggests the surveyed code involves less complex post operative care as compared to the reference code. The RUC noted that the reference code required more mental effort and judgement, more technical kill and physical effort and greater psychological stress to perform than the surveyed code. Also, the RUC also compared this procedure to 26615 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint (RUC recommended work RVU=8.00), 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC Recommended work RVU=8.00) and 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone (RUC recommended work RVU=8.00). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as well as the lower intensity and complexity measures as compared to 28299, the RUC agreed that 8.00 work RVU appropriately places 28485 in comparison to 28299, 26685, 28645 and 26615. The RUC recommends 8.00 work RVUs for 28485.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28505	Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed	090	8.00	The RUC reviewed CPT code 28505 Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed and compared it with its reference code 28750 Arthrodesis, great toe; metatarsophalangeal joint (Work RVU=8.37). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 75 minutes, respectively). Additional pre-service time is associated with the surveyed code because this procedure involves the evaluation of a fracture which requires additional positioning and prep time as compared to the reference code. The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code involves less complex post operative care as compared to the reference code. However, the RUC also compared this procedure to 26685 Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint (RUC recommended work RVU=8.00), 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed (RUC Recommended work RVU=8.00) and 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone (RUC recommended work RVU=8.00). The RUC agreed that all of these procedures had similar complexity and should have similar work RVUs. With the lower amount of intra-service time and the differences in the post-operative visits as compared to 28750, the RUC agreed that 8.00 work RVU appropriately places 28525 in comparison to 28750, 26685, 28645 and 26615. The RUC recommends 8.00 work RVUs for 28505.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	090	6.00	The RUC reviewed CPT code 28525 Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each and compared it with its reference code 28289 Hallux rigidus correction with chellectomy, debridement and capsular release of the first metatarsophalangeal joint (Work RVU=8.11). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (30 minutes and 45 minutes, respectively). Additional pre-service time is associated with the surveyed code because this procedure involves a fracture with fixation, which requires more positioning and prep time as compared to the reference code. The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code involves a less complex post operative care as compared to the reference code. The RUC also compared the intensity/complexity measures of the surveyed code and the reference code and determined that the reference code required more technical and physical skill, more psychological stress and had increased intensity to perform as compared to the surveyed code. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 28289, the RUC agreed that the 25th percentile of survey, 6.00 work RVU appropriately places 28525 in comparison to the reference code. Furthermore, the RUC compared the surveyed code with MPC code 11646 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm (Work RVU=6.21) and agreed that 6.00 RVU was an approriate value for the surveyed code because the surveyed code had significantly less intra-service time than this procedure, 30 minutes and 60 minutes, respectively. The RUC recommends 6.00 work RVUs for 28525.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	10.43	The RUC reviewed CPT code 28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed and compared it with its reference code 28261 Capsulotomy, midfoot; with tendon lengthening (Work RVU=12.91). The RUC noted that the intra-service time of 28555 is significantly less than the intra-service time of the reference code, 60 minutes and 103 minutes, respectively. The RUC reviewed the post-operative visits for this service and determined that to make this service comparable to other codes within the family, 27784 Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed (RUC recommended work RVU=10.45) and 27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed (RUC recommended work RVU=10.50), that the specialty societies' recommendation of including a 99214 office visit should be removed from the post-operative visits associated with this code as only two 99213 and two 99212 office visits is more typical of the post-operative care for the typical patient. With the lower amount of intra-service time of the surveyed code in comparison to the reference code and the same post-operative visits as 27784 and 27792, the RUC agreed that the 25th percentile of the survey, 10.43 RVUs appropriately places this code in comparison to the reference codes. For further support, the RUC compared this code to MPC code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (Work RVU=10.36) and agreed that the recommended value of 10.43 RVU for 28555 was appropriate as the intra-service time for 28555 is significantly more than the 66984, 60 minutes and 30 minutes, respectively. The RUC recommends 10.43 RVUs for 28555.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	090	12.00	The RUC reviewed CPT code 28585 Open treatment of talotarsal joint dislocation, includes internal fixation, when performed and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (work RVU=11.39). The RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and two 99212 office visits being associated with this procedure. With this change, the RUC noted that the total service times for 28585 is greater than the reference code, 324 minutes and 299 minutes. Additionally, the RUC noted that the surveyed code required greater mental effort and judgement and physicial effort to perform in comparison to the reference code. This intensity of this service is much in part due to the joint that is operated on as it is more proximal and involves larger bones as compared to the tarsometatarsal dislocation procedure. Two bones are involved in this type of dislocation and the risk for post-operative complications is high. Therefore, due more total service time and greater intensity/complexity measures as compared to the reference code, the RUC recommends the 25th percentile of the survey, 12.00 RVUs for this procedure. For further support, the RUC compared 28585 to MPC code 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy (Work RVU=12.29). The RUC noted that as 28585 has less intra-service time as compared to 60220, 75 minutes and 90 minutes, the recommended work RVU of 12.00 appropriately places this code in comparison to 60220 as well as the reference code, 28299. The RUC recommends 12.00 RVUs for 28585.

689

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	11.50	The RUC reviewed CPT code 28615 Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed and compared it to its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). After hearing the specialty societies' presentation for this code agreed that an additional 10 minutes of pre-service evaluation time and an additional 5 minutes of pre-service scrub, dress and wait time was needed to account for the fact that this procedure involves two bones which increases the complexity and risk associated with this procedure and consequently increases the evaluation and scrub, dress and wait time. Furthermore, the RUC agreed that the specialty society recommended 99214 office visit should be lowered to a 99213 office visit as this is more typical of the post-operative care for this procedure. This change in the post-operative visits results in three 99213 office visits and two 99212 office visits being associated with this procedure. With these changes, the RUC noted that 28615 had more total service time than the reference code, 323 minutes and and 299 minutes respectively. Further, the surveyed code requires greater technical skill, physicial effort and psychgological stress to perform in comparison to the reference code. Therefore the RUC agreed that the approriate value for this procedure is the 25th percentile of the survey data, 11.50 RVUs as this value appropriately places this code in comparison to the reference code. For further support the RUC compared this procedure to 28555 Open treatment of tarsal bone dislocation, includes internal fixation, when performed (RUC recommended RVU=10.43). As treating the type of dislocation involved in 28615 is more difficult than treating a dislocation involving a single bone as in 28555, the proposed value of 11.50 RVU appropriately place this procedure in comparison to 28555. The RUC recommends 11.50 RVUs for 28615
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	090	8.00	The RUC reviewed CPT code 28645 Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed and compared it with its reference code 28292 Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure (work RVU=8.72). The RUC noted that the intra-service time for the surveyed code is less than the intra-service time for the reference code (45 minutes and 60 minutes, respectively). The number of post-operative visits is the same but the surveyed code includes two 99213 and two 99212 office visits compared to the reference code with four 99213 office visits, which suggests the surveyed code has a less complex post operative care as compared to the reference code. The RUC also compared the intensity/complexity measures of the surveyed code to the reference code and determined that the reference code required more technical skill and more psychological stress. With the lower amount of intra-service time and lower intensity/complexity measures as compared to 28292, the RUC agreed that the 25th percentile of survey, 8.00 work RVU appropriately places 28645 in comparison to the reference code. The RUC recommends 8.00 work RVUs for 28645.

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CPT Code	Descriptor	Global	RUC Rec Work RVU	RUC Rationale
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	090	6.00	The RUC reviewed CPT code 28675 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed and compared it with 28288 Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head (work RVU=5.81). The RUC compared the service times of both procedures and noted that although the intra-service times are the same (30 minutes), 28675 had considerable more pre-service time associated with it than 28288 (55 minutes and 20 minutes, respectively). The surveyed code has more pre-service time associated with it because in involves a dislocation requiring fixation, which requires additional positioning and prep time. The reference code does not require fixation. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater mental effort and judgement and more overall intensity to perform than the reference code. Therefore, the RUC agreed that because of the greater amount of time and the greater mental effort and judgement associated with the surveyed code in comparison to the reference code, the RUC recommends survey median RVU, 6.00 RVUs for 28675. The RUC recommends 6.00 RVUs for 28675.

691

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27766 Tracking Number F44 Specialty Society Recommended RVU: **8.50**
Global Period: 090 RUC Recommended RVU: **8.50**

CPT Descriptor: Open treatment of medial malleolus fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 23-year-old male falls and sustains a displaced medial malleolar fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatio drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A midline longitudinal incision is made with care to protect the branches of the medial saphenous nerve and vein. Sub-periosteal exposure of the fracture line is carried out. The fracture is pulled apart and the joint is inspected and irrigated for loose fragments. The fracture is then held in a reduced position and fixed with two parallel guide wires. Properly sized screws are place to achieve reduction and compression. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
  Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	27766					
Sample Size:	250	**Resp N:** 53	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**6.00**	12.00	100.00
Survey RVW:		6.00	8.50	**10.00**	12.00	24.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		20.00	35.00	**45.00**	60.00	90.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
itical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				

Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27766		
		Specialty Recommended
Physician Work RVU:		8.50
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		45.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
43269	000	15,070	8.20	RUC Time

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50590	090	52,156	9.64	RUC Time

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 24.5 %

TIME ESTIMATES (Median)

	CPT Code: 27766	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	65.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**266.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.62	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.23	2.20
Urgency of medical decision making	2.31	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.54	2.83
Physical effort required	2.62	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.17	2.83
Outcome depends on the skill and judgment of physician	2.33	2.83
Estimated risk of malpractice suit with poor outcome	2.75	2.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.88	2.17
Intra-Service intensity/complexity	2.13	2.17
Post-Service intensity/complexity	3.75	3.33

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27766, we recommend 8.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27766 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The intra-service time for the key reference code (25607) is greater than the survey code, but 27766 requires one ni in the hospital because of the risk for post-operative complications. Total work for 27766 is only slightly less than 256. and this is reflected in the survey 25th percentile work RVU. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved digit and extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting and instruction on weight bearing activities. X-rays

would be reviewed. The second visit would be for splint and dressing removal, wound evaluation, suture removal, new splint application, and instruction on range of motion (ROM) exercises. The third visit would be for range of motion exercises and review of restrictions and review of radiographs. X-rays would be reviewed. The fourth visit would be to check X-rays, final assessment of range of motion and review activities.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example .05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 55% No 45%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 17% I do not agree 83%
B. Patients requiring this service are now:
   more complex (more work) 89% less complex (less work) 0% no change 11%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 17% no change 83%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27766

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		77.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27784 Tracking Number F45 Specialty Society Recommended RVU: **10.45**
Global Period: 090 RUC Recommended RVU: **10.45**

CPT Descriptor: Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male is struck by a blunt object and suffers a fracture of the proximal fibula requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made along the course of the proximal fibula with care to protect the peroneal nerve, which, if necessary, is retracted out of harms way. The bone fragments are reduced with a bone holding forceps and the appropriate size plate is chosen. The fracture is reduced. A plate is put into position The screw holes are then drilled and the screws are inserted. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:
- The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
esenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	27784					
Sample Size:	250	**Resp N:** 36	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**2.00**	4.00	50.00
Survey RVW:		7.00	9.00	**10.45**	14.13	25.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	45.00	**60.00**	78.00	90.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
her Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27784		
		Specialty Recommended
Physician Work RVU:		8.50
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 27.7 %

TIME ESTIMATES (Median)

	CPT Code: 27784	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**281.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.80	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.40
Urgency of medical decision making	3.00	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.90
Physical effort required	2.60	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.60
Outcome depends on the skill and judgment of physician	2.90	2.80
Estimated risk of malpractice suit with poor outcome	2.60	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.40	2.44
Intra-Service intensity/complexity	2.50	2.40
Post-Service intensity/complexity	2.50	2.60

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27784, we recommend 10.45 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27784 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Compared to the reference service code 25607, pre-service and intra-service work and times are similar The survey code has more post-operative work, because 27784 requires hospitalization to avoid skin issues, swelling and assess neurocirculatory status. Neurovascular injury may occur with this type of dislocation and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing, specifically the paranetal nerve is removed. The first office visit would include removal of the splint and dressing, wound evaluation,

redressing, discussion of restrictions and operative findings, splinting and instruction on weight bearing activities. X-rays would be reviewed. The second visit would be for splint and dressing removal, wound evaluation, suture removal, new splint application, and instruction on range of motion (ROM) exercises. The third visit would be for splint removal, removal of hardware, range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 28% No 82%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 10%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 20% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27784

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		68.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27792 Tracking Number F46 Specialty Society Recommended RVU: **10.50**
Global Period: 090 RUC Recommended RVU: **10.50**

CPT Descriptor: Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male misses the last step and falls, sustaining a displaced fracture of the lateral malleolus requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. The fracture is reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. Stability of the syndesmosis is confirmed by trying to disrupt the distal tibio - fibular junction. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	27792				
Sample Size:	250	**Resp N:** 53	**Response:** 21.2 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	6.00	**15.00**	20.00	100.00
Survey RVW:	8.00	9.00	**10.50**	13.00	25.00
Pre-Service Evaluation Time:			**40.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	30.00	45.00	**60.00**	60.00	90.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
'ritical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**			
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**			

Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27792		
		Specialty Recommended
Physician Work RVU:		10.50
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28299	090	11.39	RUC Time

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 13.2 %

TIME ESTIMATES (Median)

	CPT Code: 27792	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	75.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**281.00**	**299.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.20
Urgency of medical decision making	3.00	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.29	3.20
Physical effort required	3.43	3.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.20
Outcome depends on the skill and judgment of physician	3.00	3.40
Estimated risk of malpractice suit with poor outcome	3.00	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.86	3.00
Intra-Service intensity/complexity	3.14	3.40
Post-Service intensity/complexity	3.43	2.60

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27792, we recommend 10.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27792 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This fracture is slightly more complex than 27784 and a RVW of 10.50 maintains the rank order between these two procedures. The survey code involves more pre-service time for evaluating the fracture, the appropriate fixation, and positioning and prepping but the intra-service time for the reference code is greater. Code 27792 requires overnight hospitalization. Neurovascular injury may occur with this type of fracture and proper function must be restored so multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved

extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weight bearing activities. X-rays would be reviewed. The second visit would be for splint and dressing removal, wound evaluation, suture removal, new cast or splint application, and ROM exercises. The third visit would be for cast or splint removal and removal of hardware, range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 56% No 44%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 95%
B. Patients requiring this service are now:
   more complex (more work) 105% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 5% from inpatient to outpatient 14% no change 91%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27792

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		83.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27814 Tracking Number F47 Specialty Society Recommended RVU: **14.20**
Global Period: 090 RUC Recommended RVU: **11.50**

CPT Descriptor: Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28-year-old male slips sustaining a displaced bimalleolar fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. The fracture is reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. The wound is irrigated and closed in layers. Next, a midline longitudinal incision is made with care to protect the branches of the medial saphenous nerve and vein. Sub-periosteal exposure of the fracture line is carried out. The fracture is pulled apart and the joint is inspected and irrigated for loose fragments. The fracture is then held in a reduced position and fixed with two parallel guide wires. Properly sized screws are place to achieve reduction and compression. Stability of the syndesmosis is confirmed by trying to disrupt the distal tibio – fibular junction The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	27814					
Sample Size:	250	**Resp N:** 53	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	10.00	**17.00**	25.00	100.00
Survey RVW:		8.72	11.50	**14.20**	16.00	22.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
tra-Service Time:		40.00	75.00	**90.00**	100.00	145.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				

Other Hospital time/visit(s):	**40.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, **if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.**

CPT Code: 27814		
		Specialty Recommended
Physician Work RVU:		14.20
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 0.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 28.3 %

TIME ESTIMATES (Median)

	CPT Code: 27814	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**346.00**	**358.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.50
Urgency of medical decision making	3.83	3.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.67
Physical effort required	3.33	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.67
Outcome depends on the skill and judgment of physician	3.33	3.50
Estimated risk of malpractice suit with poor outcome	3.83	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.00
Intra-Service intensity/complexity	3.50	3.50
Post-Service intensity/complexity	3.83	2.83

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, t' treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27814, we recommend 14.20 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27814 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 25609 offers a good comparison and has a similar RVW of 14.12. Although intra-time for t. reference code is greater, the post-operative work is less because 27826 requires hospitalization to avoid skin issues, swelling and assess neurocirculatory status. Total time is similar for both codes. Neurovascular injury may occur with this type of dislocation and proper function of the joint must be restored so multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit

would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast or splint application and ROM exercises. The third visit would be for splint or cast and dressing removal, wound evaluation, hardware removal, review of restrictions and ROM exercises. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 64% No 36%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 4% I do not agree 96%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 21% no change 79%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27814

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		87.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27822 Tracking Number F48 Specialty Society Recommended RVU: **14.75**
Global Period: 090 RUC Recommended RVU: **12.12**

CPT Descriptor: Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27-year-old female falls on an incline and sustains a trimalleolar ankle fracture requiring open reduction and internal fixation of the medial and/or lateral malleolus.

Percentage of Survey Respondents who found Vignette to be Typical: 64%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. The size and position of the posterior lip is confirmed. The fracture is reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. The wound is irrigated and closed in layers. Next, a midline longitudinal incision is made with care to protect the branches of the medial saphenous nerve and vein. Sub-periosteal exposure of the fracture line is carried out. The fracture is pulled apart and the joint is inspected and irrigated for loose fragments. The fracture is then held in a reduced position and fixed with two parallel guide wires. Properly sized screws are place to achieve reduction and compression. Stability of the syndesmosis is confirmed by trying to disrupt the distal tibio - fibular junction. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	27822				
Sample Size:	250	**Resp N:** 44	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	2.00	10.00	**12.00**	21.00	100.00
Survey RVW:	9.35	11.20	**14.75**	16.00	30.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	30.00	60.00	**90.00**	90.00	140.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**40.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27822		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		
Pre-Service Positioning Time:		
Pre-Service Scrub, Dress, Wait Time:		
Intra-Service Time:		
Immediate Post Service-Time:	____	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x 99232x 99233x
Discharge Day Mgmt:	0.0	99238x 99239x
Office time/visit(s):	0.0	99211x 12x 13x 14x 15x
Prolonged Services:	0.0	99354x 55x 56x 57x

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28299	090	11.39	RUC Time

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 13.6 %

TIME ESTIMATES (Median)

	CPT Code: 27822	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	70.00	75.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**353.00**	**299.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.50
Urgency of medical decision making	3.83	3.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.67
Physical effort required	3.33	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.67
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	2.83	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.83	3.00
Intra-Service intensity/complexity	3.33	3.50
Post-Service intensity/complexity	3.83	2.83

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

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Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

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For revised code 27822, we recommend 14.75 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27822 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This fracture is slightly more complex than key reference code 28299 and similar code 27814 and a RVW of 14. maintains the rank order relative to these two procedures. Total time is greater than 28299, including hospitalization w. close monitoring because of the significant risk for complications. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of

motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

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CPT Code: 27822

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213: 2.0	
		99214: 1.0	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27823 Tracking Number F49 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **14.26**

CPT Descriptor: Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27-year-old female falls on an incline and sustains a trimalleolar ankle fracture requiring open reduction and internal fixation of the medial and/or lateral malleolus, as well as the posterior lip.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulat. drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. The soft tissue attachments of the distal fibula, with the exception of the ankle ligaments, are released and the fibula is turned down to expose the posterior ankle joint from the lateral side. The posterior lip is reduced, held in place with provisional guide wires, and then fixed with two front to back compression screws. The fibular fracture is then reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. The wound is irrigated and closed in layers. Next, a midline medial longitudinal incision is made over the medial malleolus with care to protect the branches of the medial saphenous nerve and vein. Sub-periosteal exposure of the fracture line is carried out. The fracture is pulled apart and the joint is inspected and irrigated for loose fragments. The fracture is then held in a reduced position and fixed with two parallel guide wires. Properly sized screws are place to achieve reduction and compression. Stability of the syndesmosis is confirmed by trying disrupt the distal tibio – fibular junction. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.

- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	27823				
Sample Size:	250	**Resp N:** 44	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	2.00	10.00	**12.00**	21.00	100.00
Survey RVW:	10.00	14.00	**15.00**	18.13	34.00
re-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	40.00	90.00	**98.00**	120.00	160.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	40.0	99231x **0.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**
Office time/visit(s):	85.0	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27823		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		
Pre-Service Positioning Time:		
Pre-Service Scrub, Dress, Wait Time:		
Intra-Service Time:		
Immediate Post Service-Time:	____	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x 99292x
Other Hospital time/visit(s):	**0.0**	99231x 99232x 99233x
Discharge Day Mgmt:	**0.0**	99238x 99239x
Office time/visit(s):	**0.0**	99211x 12x 13x 14x 15x
Prolonged Services:	**0.0**	99354x 55x 56x 57x

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	**RUC Time**

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	**RUC Time**

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	**RUC Time**

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 38.6 %

TIME ESTIMATES (Median)

	CPT Code: 27823	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	75.00	65.00	
Median Intra-Service Time	98.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	85.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**366.00**	**358.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.50
Urgency of medical decision making	3.83	3.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.67
Physical effort required	3.33	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.67
Outcome depends on the skill and judgment of physician	3.33	3.50
Estimated risk of malpractice suit with poor outcome	2.83	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.83	3.00
Intra-Service intensity/complexity	3.33	3.50
Post-Service intensity/complexity	3.83	2.83

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, t' treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27823, we recommend 15.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27823 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This fracture is slightly more complex than 27822 and a RVW of 15.00 maintains the rank order between these two procedures. The key reference service of 25609 has very similar total time of 358 compared the total recommended time for the survey of 366. However, the intensity and risk for complications involved in treating the trimalleolar ankle fracture is greater than that involved with 25609. 27823 involves hospitalization for close monitoring because of the significant risk for complications. Neurovascular injury may occur with this type of fracture and multiple post-operative

visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 64% No 36%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 4% I do not agree 96%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 13% no change 83%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27823

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		98.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27826 Tracking Number F50 Specialty Society Recommended RVU: **14.00**
Global Period: 090 RUC Recommended RVU: **12.00**

CPT Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female trips, fracturing the distal tibial articular surface with an adjacent displaced distal fibular fracture. An anatomic open reduction of the distal fibula and internal fixation is performed to restore alignment of the fractured tibia and fibula.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. Stability of the fractured articular surface of the tibia is confirmed. The fibular fracture is reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. Stability of the syndesmosis is confirmed by trying to disrupt the distal tibio – fibular junction. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	27826					
Sample Size:	250	**Resp N:** 36	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**3.00**	7.00	50.00
Survey RVW:		8.00	11.00	**14.00**	18.25	35.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		40.00	45.00	**60.00**	90.00	150.00
nmediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**40.0**	99231x **0.0**	99232x **1.0**	99233x **0.0**		

Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(
99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (3

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27826		
		Specialty Recommended
Physician Work RVU:		14.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 0.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25609	090	14.12	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 1 Total thyroid lobectomy, unilateral; with or without isthmusectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,163	16.60	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 19.4 %

TIME ESTIMATES (Median)

	CPT Code: 27826	Key Reference CPT Code: 25609	Source of Time RUC Time
Median Pre-Service Time	75.00	65.00	
Median Intra-Service Time	60.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	85.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**328.00**	**358.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.43	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.57	3.50
Physical effort required	3.71	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.29	3.17
Outcome depends on the skill and judgment of physician	3.00	3.17
Estimated risk of malpractice suit with poor outcome	2.86	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.86	3.17
Intra-Service intensity/complexity	3.14	3.00
Post-Service intensity/complexity	3.14	3.17

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, t' treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27826, we recommend 14.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27826 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 25609 offers a good comparison and has a similar RVW of 14.12. Although intra-time for the reference code is greater, the post-operative work is less because 27826 requires hospitalization to avoid skin issues, swelling and assess neurocirculatory status. Total time is similar for both codes. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing,

wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 64% No 36%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 17% I do not agree 83%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 4% no change 91%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27826

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27827 Tracking Number F51 Specialty Society Recommended RVU: **20.00**
Global Period: 090 RUC Recommended RVU: **16.00**

CPT Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old male with a displaced articular (pilon) fracture of the distal tibia undergoes open reduction and internal fixation of the distal tibia and its articular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A medial or anteromedial incision is made, protecting the underlying neurovascular structures, and the fracture fragments are exposed. A Schantz pin or femoral distractor is applied to take advantage of ligamentotaxis. An appropriate sized and shaped plate is chosen. Preliminary fixation is carried out with pins and final fixation is with plate and screws. Most fracture fragments are fixed to the plate, but some are just fixed fragment to fragment. The stability of the distal tibio-fibular syndesmosis is confirmed. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	27827					
Sample Size:	250	Resp N:	36	Response: 0.0 %		
Sample Type:	Random					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	3.00	**5.00**	10.00	50.00
Survey RVW:		13.00	16.00	**20.00**	25.75	30.00
Pre-Service Evaluation Time:				**55.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		75.00	120.00	**120.00**	150.00	210.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	60.0	99231x **1.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				

Office time/visit(s):	**125.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27827		
		Specialty Recommended
Physician Work RVU:		20.00
Pre-Service Evaluation Time:		55.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	108.0	99211x 0.0 12x 1.0 13x 4.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27447	090	23.04	RUC Time

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
37215	090	6992	19.58	RUC Time

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	RUC Time

CPT Descriptor 2 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 22.2 %

TIME ESTIMATES (Median)

	CPT Code: 27827	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	85.00	75.00	
Median Intra-Service Time	120.00	124.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	108.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**441.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.75	4.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.57
Urgency of medical decision making	4.75	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.75	4.29
Physical effort required	4.38	4.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.38	3.86
Outcome depends on the skill and judgment of physician	4.88	4.29
Estimated risk of malpractice suit with poor outcome	4.13	3.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.25	3.86
Intra-Service intensity/complexity	4.50	4.14
Post-Service intensity/complexity	4.13	3.29

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

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During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27827, we recommend 20.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27827 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 27447 offers a good comparison to 27827. Although both codes have a similar total time, 27447 has a greater intensity and complexity with additional hospital work. In comparing the survey code against the reference code, the median RVW appears appropriate and maintains relativity. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound

evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 68% No 32%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 22% I do not agree 78%
B. Patients requiring this service are now:
   more complex (more work) 104% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27827

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		150.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 5.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 4.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27828 Tracking Number F52 Specialty Society Recommended RVU: **24.00**
Global Period: 090 RUC Recommended RVU: **20.00**

CPT Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male falls sustaining a displaced fracture of the distal tibial articular surface including the tibia and fibula. An open reduction of the fracture and internal fixation is performed to restore the articular surface of the distal tibia and fibula.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. Stability of the fractured articular surface of the tibia is confirmed. The fibular fracture is reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. A medial or anteromedial incision is made protecting the underlying neurovascular structures, the fracture fragments are exposed. A Schantz pin or femoral distractor is applied to take advantage of ligamentotaxis. An appropriate sized and shaped plate is chosen. Preliminary fixation is carried out with pins and final fixation is with plate and screws. Most fracture fragments are fixed to the plate, but some are just fixed fragment to fragment. Stability of the syndesmosis is confirmed by trying to disrupt the distal tibio - fibular junction. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.

- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	27828				
Sample Size:	250	**Resp N:** 36	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	4.00	**5.00**	10.00	50.00
Survey RVW:	15.00	20.00	**24.00**	28.50	40.00
Pre-Service Evaluation Time:			**55.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	100.00	129.00	**150.00**	180.00	240.00
Immediate Post Service-Time:	**30:00**				

CPT Code: 27828

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.00 99239x 0.00
Office time/visit(s):	125.0	99211x 0.0 12x 1.0 13x 3.0 14x 1.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27828		
		Specialty Recommended
Physician Work RVU:		24.00
Pre-Service Evaluation Time:		55.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		150.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	108.0	99211x 0.0 12x 1.0 13x 4.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27447	090	23.04	RUC Time

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	RUC Time

CPT Descriptor 1 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
63051	090	996	25.38	RUC Time

CPT Descriptor 2 Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 30.5 %

TIME ESTIMATES (Median)

	CPT Code: 27828	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	85.00	75.00	
Median Intra-Service Time	150.00	124.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	108.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**471.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.45	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.78
Urgency of medical decision making	4.55	3.44

Technical Skill/Physical Effort (Mean)

Technical skill required	4.91	4.11
Physical effort required	4.91	3.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.55	3.67
Outcome depends on the skill and judgment of physician	4.91	4.22
Estimated risk of malpractice suit with poor outcome	4.27	3.78

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.18	3.78
Intra-Service intensity/complexity	4.36	3.67
Post-Service intensity/complexity	3.73	2.78

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27828, we recommend 24.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27828 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 27447 offers a good comparison to 27827. In comparison to 27447, the survey code total time almost identical with 27447 having more hospital work and 27828 having more intra and office work. The consensus panel believes the difference in work RVUs for these two codes correctly reflect these differences. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and

instruction on range of motion (ROM) and weight bearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 69% No 31%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 92% less complex (less work) 0% no change 8%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 96%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27828

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		180.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 6.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		150.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 4.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27829 Tracking Number F53 Specialty Society Recommended RVU: **9.50**
Global Period: 090 RUC Recommended RVU: **9.50**

CPT Descriptor: Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old male trips and sustains a severe torsional injury to his ankle resulting in a syndesmosis disruption requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatic drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal anterior incision is made down the tibiofibular syndesmosis. If this is a fresh injury, the tissues are mobilized for later repair. If this is a late injury. the scar tissue will have to be mobilized to allow for anatomic reduction. A bone holding clamp is used to obtain reduction and with the ankle in neutral mortise. Two screws with washers and/or a small plate are placed to maintain reduction without compression. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	27829				
Sample Size:	250	**Resp N:** 45	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	3.00	**6.00**	15.00	100.00
Survey RVW:	6.00	9.50	**11.00**	14.00	25.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	25.00	35.00	**45.00**	60.00	120.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			

CPT Code: 27829

Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38): 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (3(

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27829		
		Specialty Recommended
Physician Work RVU:		9.50
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		45.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25607	090	9.35	RUC Time

CPT Descriptor Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14060	090	91,000	9.07	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50590	090	52,156	9.64	RUC Time

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 11.1 %

TIME ESTIMATES (Median)

	CPT Code: 27829	Key Reference CPT Code: 25607	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**271.00**	**275.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.17
Urgency of medical decision making	3.29	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.71	3.00
Physical effort required	3.43	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.43	2.67
Outcome depends on the skill and judgment of physician	3.00	2.83
Estimated risk of malpractice suit with poor outcome	2.71	2.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.50
Intra-Service intensity/complexity	2.86	2.33
Post-Service intensity/complexity	2.67	2.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, t' treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27829, we recommend 9.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27829 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 25607 offers a good comparison and has a very similar RVW of 9.35. The intra-service time is 1. minutes higher for the reference code compared to the survey code, but the survey code has more pre-service time for evaluation of the fracture. The intensity and risk for complications involved in treating the distal tibia fracture is much greater than that involved with 25607. The survey code has more post-operative work, because 27829 requires hospitalization to avoid skin issues, swelling and assess neurocirculatory status. Neurovascular injury may occur with

this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 31% No 69%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 29% I do not agree 71%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 50% no change 50%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27829

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:27832 Tracking Number F54 Specialty Society Recommended RVU: **11.00**
Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old male is hit from the side resulting in a proximal tibiofibular disruption requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal lateral incision is made. The lateral collateral ligament, arcuate ligament, fabellofibular ligament, popliteal fibular ligament, popliteus, biceps femoris tendon, and common peroneal tendon and it sheath are identified and dissected. The peroneal nerve is identified, dissected, and protected. Only then is the dissection carried down to the disrupted capsule and the dislocated proximal tibio-fibular joint. If this is a late injury, the scar tissue will have to be mobilized to allow for an anatomical reduction. Bone reduction clamps are used to obtain reduction and then provisional fixation (K-wires) are placed to maintain the reduction. The reduction is confirmed. One or two screws are placed through the fibular head into the proximal tibial metaphysis to maintain reduction, protecting the peroneal nerve which is always in proximity. The attached ligaments are repaired/stabilized as necessary to prevent knee instability. If the joint cannot be congruously reduced or there is fracture comminution, the proximal fibula may be completely or partly excised. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	27832				
Sample Size:	250	**Resp N:** 36	**Response:** 14.4 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**0.00**	1.00	50.00
Survey RVW:	6.48	9.46	**11.00**	15.25	28.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	30.00	60.00	**75.00**	90.00	120.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 27832		
		Specialty Recommended
Physician Work RVU:		11.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		75.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2230788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 22.2 %

TIME ESTIMATES (Median)

	CPT Code: 27832	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	75.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**301.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.75
Urgency of medical decision making	3.50	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	3.25
Physical effort required	3.13	2.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.25	2.88
Outcome depends on the skill and judgment of physician	3.50	3.25
Estimated risk of malpractice suit with poor outcome	2.88	2.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.00	2.88
Post-Service intensity/complexity	2.63	2.63

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, th/ treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 27832, we recommend 11.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 27832 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 25608 offers a good comparison and has a very similar RVW of 10.86. Although intra-service tim greater for the reference code, 27832 requires overnight hospitalization to avoid skin issues, swelling and assess neurocirculatory status. The intensity and risk for complications involved in open treatment the trimalleolar ankle fracture is much greater than that involved with 25608. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing,

discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 25% No 75%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) 0% no change 30%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 40% no change 70%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27832

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		72.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		75.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28415 Tracking Number F55 Specialty Society Recommended RVU: **20.06**
Global Period: 090 RUC Recommended RVU: **17.54**

CPT Descriptor: Open treatment of calcaneal fracture, includes internal fixation, when performed;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male falls and sustains a comminuted calcaneal fracture. To reconstruct the fracture and joint surface, an open reduction and internal fixation of the intra-articular fracture of the calcaneus is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulati drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An L-shaped lateral incision is made to the hindfoot. The posterior L is along the border of the posterior lateral skin, turns at the heel and proceeds along the border of the plantar lateral skin. The incision is taken down to bone and subperiosteally dissected up to the subtalar joint, with care to protect the sural nerve. With adequate exposure k-wires are inserted into the fibula and talus to gently act as retractors of the skin. The lateral wall of the fracture is mobilized so that the depressed portions of the posterior and middle facet can be visualized. With the aid of a Schantz pin, the fragments are mobilized to anatomic position and a calcaneal plate is contoured to maintain the reduction from the posterior calcaneus to the calcaneocuboid joint. Bohler's angle is restored. Initial reduction is carried out with guide wires and secured with screw fixation. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.

- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28415					
Sample Size:	250	**Resp N:**	54	**Response:** 21.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	6.00	**10.00**	15.00	30.00
Survey RVW:		11.00	16.00	**20.06**	25.00	40.00
Pre-Service Evaluation Time:				**55.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
ntra-Service Time:		60.00	120.00	**120.00**	140.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				

Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**125.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28415		
		Specialty Recommended
Physician Work RVU:		20.06
Pre-Service Evaluation Time:		55.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	108.0	99211x 0.0 12x 1.0 13x 4.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28705	090	20.12	RUC Time

CPT Descriptor Arthrodesis; pantalar

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
37215	090	6,992	19.58	RUC Time

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	RUC Time

CPT Descriptor 2 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 24.0 %

TIME ESTIMATES (Median)

	CPT Code: 28415	Key Reference CPT Code: 28705	Source of Time RUC Time
Median Pre-Service Time	85.00	75.00	
Median Intra-Service Time	120.00	180.00	
Median Immediate Post-service Time	30.00	35.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	108.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**441.00**	**490.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.31	4.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	4.20
Urgency of medical decision making	4.54	3.90

Technical Skill/Physical Effort (Mean)

Technical skill required	4.77	4.20
Physical effort required	4.15	4.10

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.67	4.44
Outcome depends on the skill and judgment of physician	4.75	4.44
Estimated risk of malpractice suit with poor outcome	4.62	4.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	4.00
Intra-Service intensity/complexity	4.75	3.90
Post-Service intensity/complexity	4.62	3.70

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

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A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28415, we recommend 20.06 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28415 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 28705 offers a very close comparison to the total work 28415. Although 28705 requires more intra-time, the intensity and risk for complications involved in treating the calcaneal fracture is much greater. In comparing the survey code against the reference code, the median RVW appears appropriate and maintains relativity. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal

of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 60% No 40%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 15% I do not agree 85%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 3% from inpatient to outpatient 6% no change 91%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28415

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		150.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 5.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 4.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28420 Tracking Number F56 Specialty Society Recommended RVU: **23.50**
Global Period: 090 RUC Recommended RVU: **19.00**

CPT Descriptor: Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female falls sustaining a calcaneal fracture with severe loss of Bohler's angle requiring open reduction and internal fixation. To make up for crushed bone, a separate incision is made in the iliac crest where a large bone graft is harvested and used for fracture stabilization. [Please note that total physician work for this service includes both ORIF and obtaining bone graft.]

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An L-shaped lateral incision is made to the hindfoot. The posterior L is along the border of the posterior lateral skin, turns at the heel and proceeds along the border of the plantar lateral skin. The incision is taken down to bone and subperiosteally dissected up to the subtalar joint, with care taken to protect the sural nerve. With adequate exposure, k-wires are inserted into the fibula and talus to gently act as retractors of the skin. The lateral wall of the fracture is mobilized so that the depressed portions of the posterior and middle facet can be visualized. With the aid of a Schantz pin the fragments are mobilized to anatomic position and a calcaneal plate is contoured to maintain the reduction from the posterior calcaneus to the calcaneocuboid joint. Because large gaps are seen in bone contact secondary to crushing, a separate incision is made at the iliac crest and a large bone graft is obtained. The iliac crest wound is irrigated and closed in layers. Bohler's angle is restored. Initial reduction is carried out with guide wire and secured with screw fixation. Bone graft is packed in prior to plate application to fill the gaps. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint

- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	28420				
Sample Size:	250	**Resp N:** 54	**Response:** 0.0 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**1.00**	5.00	30.00
Survey RVW:	12.00	19.00	**23.50**	27.00	45.00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**20.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		

CPT Code: 28420

Intra-Service Time:		90.00	120.00	**150.00**	179.00	240.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	60.0	99231x **1.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	125.0	99211x **0.0** 12x **1.0** 13x **3.0** 14x **1.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, **if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.**

CPT Code: 28420		
		Specialty Recommended
Physician Work RVU:		**23.50**
Pre-Service Evaluation Time:		**60.0**
Pre-Service Positioning Time:		**20.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**150.00**
Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**108.0**	99211x **0.0** 12x **1.0** 13x **4.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27487	090	26.91	**RUC Time**

CPT Descriptor Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	**RUC Time**

CPT Descriptor 1 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
63051	090	996	25.38	**RUC Time**

CPT Descriptor 2 Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-plates), when performed)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 22.2 %

TIME ESTIMATES (Median)

	CPT Code: 28420	Key Reference CPT Code: 27487	Source of Time RUC Time
Median Pre-Service Time	95.00	60.00	
Median Intra-Service Time	150.00	200.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	108.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**481.00**	**520.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.91	4.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.91	4.50
Urgency of medical decision making	4.82	4.40

Technical Skill/Physical Effort (Mean)

Technical skill required	4.91	4.50
Physical effort required	4.73	4.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	4.30
Outcome depends on the skill and judgment of physician	4.91	4.30
Estimated risk of malpractice suit with poor outcome	4.55	4.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.70
Intra-Service intensity/complexity	4.18	4.00
Post-Service intensity/complexity	4.36	3.10

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

  Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

  Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28420, we recommend 23.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28420 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The reference code 27487 offers a good comparison to 28420. The survey code total time is slightly less than 27487. The consensus panel believes the difference in work RVUs for these two codes correctly reflect the additional intra-operative work for 27487 and differences in number and level of postoperative visits between the codes. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal

of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 61% No 39%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 13% I do not agree 87%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 3% from inpatient to outpatient 6% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28420

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		133.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.5	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		150.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 4.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28445 Tracking Number F57 Specialty Society Recommended RVU: **21.50**
Global Period: 090 RUC Recommended RVU: **17.07**

CPT Descriptor: Open treatment of talus fracture, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old man suffers a displaced talar neck fracture where the body of the talus is extruded from the ankle joint, the medial malleolus is fractured, and the lateral foot skin is stretched and tented requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatio drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A dorsomedial incision is made in the interval between the tibialis anterior and the posterior tibial tendon. The medial malleolus is mobilized and the joint inspected. Fracture debris is removed. The talar body is manually reduced in the ankle joint and at the talar neck. This may require the insertion of a calcaneal pin for traction. A counter dorsolateral incision is made to aid in reduction and prevent varus or valgus angulation of the talar neck. K-wires are used for temporary fixation and imaging confirms reduction. Final fixation is completed with two compression screws inserted in the longitudinal axis of the talus. Two parallel compression screw are used to effect reduction of the medial malleolus. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28445					
Sample Size:	250	**Resp N:** 54	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**4.00**	6.00	30.00
Survey RVW:		12.00	17.00	**21.50**	25.00	40.00
Pre-Service Evaluation Time:				**58.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		90.00	109.00	**120.00**	150.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**				

Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**125.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **1.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28445		
		Specialty Recommended
Physician Work RVU:		21.50
Pre-Service Evaluation Time:		58.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	108.0	99211x 0.0 12x 1.0 13x 4.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27447	090	23.04	RUC Time

CPT Descriptor Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
37215	090	6,992	19.58	RUC Time

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50546	090	2,260	21.69	RUC Time

CPT Descriptor 2 Laparoscopy, surgical; nephrectomy, including partial ureterectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 18.5 %

TIME ESTIMATES (Median)	CPT Code: 28445	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	88.00	75.00	
Median Intra-Service Time	120.00	124.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	108.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**444.00**	**469.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.60	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.22
Urgency of medical decision making	4.70	2.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.30	3.78
Physical effort required	4.60	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.70	3.22
Outcome depends on the skill and judgment of physician	4.70	3.56
Estimated risk of malpractice suit with poor outcome	4.60	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.40	2.89
Intra-Service intensity/complexity	3.90	3.00
Post-Service intensity/complexity	4.30	1.67

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, th treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28445, we recommend 21.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28445 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This fracture is slightly less complex than 28420 and a RVW of 21.50 maintains the rank order between these two procedures. In comparison to key reference code 27447, the survey code total time is almost identical with 27447 having more hospital work and 28445 having more office work. The consensus panel believes the difference in work RVUs for these two codes correctly reflect the additional post-operative work and slightly greater intensity for the key reference code. Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary.

Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 59% No 41%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 91% less complex (less work) 0% no change 9%
C. The usual site-of-service has changed:
   from outpatient to inpatient 6% from inpatient to outpatient 6% no change 88%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28445

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		125.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213: 2.0	
		99214: 1.0	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		120.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 4.0	
		99214:	
		99215:	

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28465 Tracking Number F58 Specialty Society Recommended RVU: **10.50**
Global Period: 090 RUC Recommended RVU: **9.50**

CPT Descriptor: Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male sustains a displaced cuboid fracture requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatic drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made over the dorsum of the cuboid. The fracture is revealed via blunt and sharp dissection. Depending on the fracture configuration, one or more pins or a mini-fragment plate and screws are used to achieve reduction. Anatomic reduction of the adjacent joints is confirmed. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.

- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	28465				
Sample Size: 300	**Resp N:** 77	**Response:** 25.6 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**4.00**	6.00	20.00
Survey RVW:	6.00	10.50	**13.50**	15.00	23.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	30.00	60.00	**60.00**	90.00	125.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28465		
		Specialty Recommended
Physician Work RVU:		10.50
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25608	090	10.86	RUC Time

CPT Descriptor Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
28299	090	3,398	11.39	RUC Time

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 16.8 %

TIME ESTIMATES (Median)

	CPT Code: 28465	Key Reference CPT Code: 25608	Source of Time RUC Time
Median Pre-Service Time	70.00	65.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	101.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**257.00**	**305.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.54	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.77	2.77
Urgency of medical decision making	3.08	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.38
Physical effort required	2.62	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.31	3.23
Outcome depends on the skill and judgment of physician	3.54	3.31
Estimated risk of malpractice suit with poor outcome	2.77	2.85

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.92	2.69
Intra-Service intensity/complexity	2.92	2.69
Post-Service intensity/complexity	2.77	2.69

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28465, we recommend 10.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28465 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The consensus panel compared the key reference code 25608 and the recommendation for a similar code 28555 to develop the recommendation for 28465. Compared to 28555, the intensity of 28465 is greater. Because of the type of injury or trauma required to cause a fracture of a tarsal bone, the risk for complications, including compartment syndrome, is significant, and greater than a 2 part DRF. Because the consensus panel believes all three codes require similar total work, the 25th percentile work RVU is recommended.

Neurovascular injury and compartment syndrome may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion and weightbearing activities. X-rays wou be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, n cast application, ROM exercises. The third visit would be for cast removal and range of motion exercises and review o restrictions. X-rays would be reviewed. Physical therapy recommendations would be communicated. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 65% No 35%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 90% less complex (less work) 0% no change 10%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 24% no change 73%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28465

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		88.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28485 Tracking Number F59 Specialty Society Recommended RVU: **8.00**
Global Period: 090 RUC Recommended RVU: **8.00**

CPT Descriptor: Open treatment of metatarsal fracture, includes internal fixation, when performed, each

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 31-year-old male slips and sustains a displaced fracture of the first metatarsal requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made over the dorsum of the metatarsal. The fracture is revealed via blunt and sharp dissection. Depending on the fracture configuration, one or more pins or a mini-fragment plate and screws are used to achieve reduction. The wound is irrigated and closed in layers..

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart

- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28485					
Sample Size:	300	**Resp N:** 77	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**5.00**	10.00	40.00
Survey RVW:		6.10	9.00	**11.00**	12.30	20.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		24.00	45.00	**60.00**	70.00	100.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28485		
		Specialty Recommended
Physician Work RVU:		8.00
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28299	090	11.39	RUC Time

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	RUC Time

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	14,040	8.44	RUC Time

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 19.4 %

TIME ESTIMATES (Median)

	CPT Code: 28485	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	75.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**242.00**	**299.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	3.09
Urgency of medical decision making	3.07	3.09

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.91
Physical effort required	3.40	3.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.18
Outcome depends on the skill and judgment of physician	3.13	3.27
Estimated risk of malpractice suit with poor outcome	3.07	3.10

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.00	2.91
Post-Service intensity/complexity	3.33	2.64

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

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Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

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For revised code 28485, we recommend 8.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28485 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

A wide range of reference codes were selected by survey respondents. A consensus panel compared open treatment of a metatarsal fracture to open treatment of a metacarpal fracture (26615) and believes the procedures are similar. Code 28485 has 60 minutes of intra-service time compared to 45 minutes for code 26615. Additionally, the pre-service time for the survey code is 10 minutes more. Both codes have four post-operative visits recommended (99213 x 2, 99212 x 2). The consensus panel believes that code 26615 is a better comparison against the survey code and recommends an

RVW of 8.00 for the survey code, which is slightly less than the 25th percentile and equal to the recommendation for code 26615. The consensus panel believes that since the procedures are similar, the recommended RVWs should be the same.

Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast or splint application, ROM exercises. The third visit would be for splint or cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

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   I agree 19% I do not agree 81%
B. Patients requiring this service are now:
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C. The usual site-of-service has changed:
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Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		59.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28505 Tracking Number F60 Specialty Society Recommended RVU: **8.30**
Global Period: 090 RUC Recommended RVU: **8.00**

CPT Descriptor: Open treatment of fracture great toe, phalanx or phalanges, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male fractures the proximal and distal phalanx of the great toe requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatior drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made over the dorsum of the great toe. The fractures are revealed via blunt and sharp dissection. Depending on the fracture configuration one or more pins or a mini-fragment plate and screws are used to achieve reduction of the proximal and distal phalanx. Anatomic reduction of the joints is confirmed. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report

- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28505					
Sample Size:	300	**Resp N:** 77	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**4.00**	5.00	40.00
Survey RVW:		4.00	8.30	**9.00**	10.50	20.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		20.00	35.00	**45.00**	60.00	100.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28505		
		Specialty Recommended
Physician Work RVU:		8.30
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		45.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28750	090	8.37	RUC Time

CPT Descriptor Arthrodesis, great toe; metatarsophalangeal joint

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	RUC Time

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	14,040	8.44	RUC Time

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 32.4 %

TIME ESTIMATES (Median)

	CPT Code: 28505	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	65.00	40.00	
Median Intra-Service Time	45.00	75.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	78.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**227.00**	**237.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.88	2.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.72	2.75
Urgency of medical decision making	2.84	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	3.28	3.20
Physical effort required	2.80	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.63	2.70
Outcome depends on the skill and judgment of physician	2.71	2.75
Estimated risk of malpractice suit with poor outcome	2.58	2.58

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.85	2.50
Intra-Service intensity/complexity	2.75	2.25
Post-Service intensity/complexity	2.80	2.42

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28505, we recommend 8.30 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28505 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Survey code 28505 and key reference code 28750 both involve the great toe and both involve the use of hardware. The reference code has a work RVU that is slightly higher (8.37) than the recommended 25th percentile (8.30) for the survey code and the total time is similar (237 reference and 227 survey). The survey code has more pre-service time because of the time involved in evaluating a fracture and positioning and prepping but the intra-service time for the reference code

(75) is higher compared to that for the survey code (45). The codes include the same number of post-operative visits but two of the visits for the survey code are less intense (99213 x 2, 99212 x 2, survey vs. 99213 x 4, reference). A consensus panel agrees that the RVW for the survey code should be lower than that for the reference code and recommending the median RVW of 9.00 would result in a rank order anomaly. Therefore, the consensus panel recommends the 25th percentile RVW of 8.30.

Neurovascular injury may occur with this type of fracture and proper function must be restored so multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint and dressing removal, wound evaluation, suture removal, new cast or splint application, and ROM exercises. The third visit would be for cast or splint removal, range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 49% No 51%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 76% less complex (less work) 0% no change 24%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 37% no change 63%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28505

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28525 Tracking Number F61 Specialty Society Recommended RVU: **6.00**
Global Period: 090 RUC Recommended RVU: **6.00**

CPT Descriptor: Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female sustained a displaced lessor toe fracture requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made over the dorsum of the toe. The fracture is revealed via blunt and sharp dissection. Depending on the fracture configuration one or more pins or a mini-fragment plate and screws are used to achieve reduction. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report

- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office
- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	28525				
Sample Size: 300	**Resp N:** 59	**Response:** 0.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**4.00**	7.00	25.00
Survey RVW:	3.00	6.00	**8.00**	9.00	12.00
Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	15.00	30.00	**30.00**	45.00	90.00
Immediate Post Service-Time:	**20.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28525		
		Specialty Recommended
Physician Work RVU:		6.00
Pre-Service Evaluation Time:		35.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		30.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28289	090	8.11	RUC Time

CPT Descriptor Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99291	XXX	3,260,677	4.50	RUC Time

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
11646	010	10,371	6.21	RUC Time

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 23.7 %

TIME ESTIMATES (Median)

	CPT Code: 28525	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	60.00	30.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	78.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**207.00**	**197.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.77	2.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.23	2.31
Urgency of medical decision making	2.00	2.23

Technical Skill/Physical Effort (Mean)

Technical skill required	2.38	2.69
Physical effort required	2.08	2.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.08	2.46
Outcome depends on the skill and judgment of physician	2.23	2.31
Estimated risk of malpractice suit with poor outcome	2.08	2.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.08	2.31
Intra-Service intensity/complexity	2.08	2.15
Post-Service intensity/complexity	2.85	1.92

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28525, we recommend 6.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28525 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The intra-service time for the reference code (28289) is 45 minutes compared to 30 minutes for the survey code. Additional pre-service time is necessary for 28525 because this procedure involves a fracture with fixation, which requires more positioning and prep time. The number of post-operative visits is the same but the survey code includes two 99213 and two 99212 visits compared to the reference code with four 99213 visits. The recommended RVW of the

survey code is lower than that of the reference code. Due to the trauma involved with fractures, the risk for post-operative complications remains and the number and type of visits are believed to be appropriate.

Neurovascular injury may occur with this type of fracture and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved digit and extremity is ongoing. The first office visit would nclude removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting and instruction on weightbearing activities. X-rays would be reviewed. The second visit would be for splint and dressing removal, wound evaluation, suture removal, new splint application, and instruction on range of motion (ROM) exercises. The third visit would be for splint removal, removal of hardware, range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 54% No 46%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 13% I do not agree 88%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 19% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 25825

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		48.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 48.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 30.0	Staff % of Physician time **Change: In Time** 18.00
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28555 Tracking Number F62 Specialty Society Recommended RVU: **10.43**
Global Period: 090 RUC Recommended RVU: **10.43**

CPT Descriptor: Open treatment of tarsal bone dislocation, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old male sustains a dislocation of the middle cuneiform requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatio' drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A dorsal longitudinal incision is made over the metatarso-cuneiform joint. Blunt dissection reveals the dislocation. The joint is manually reduced and temporarily fixated with a k-wire Two screws are placed across the joint to provide fixation. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This require. removing and reapplying the dressings.

Discharge day:
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28555					
Sample Size:	300	**Resp N:** 59	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**3.00**	5.00	30.00
Survey RVW:		8.00	10.43	**12.00**	14.50	28.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		25.00	45.00	**60.00**	90.00	180.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**				

Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28555		
		Specialty Recommended
Physician Work RVU:		**10.43**
Pre-Service Evaluation Time:		**40.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**60.00**
Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28261	090	12.91	**RUC Time**

CPT Descriptor Capsulotomy, midfoot; with tendon lengthening

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	**RUC Time**

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	**RUC Time**

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 15.2 %

TIME ESTIMATES (Median)

	CPT Code: 28555	Key Reference CPT Code: 28261	Source of Time RUC Time
Median Pre-Service Time	65.00	60.00	
Median Intra-Service Time	60.00	103.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	78.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**281.00**	**343.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.89
Urgency of medical decision making	3.44	2.89

Technical Skill/Physical Effort (Mean)

Technical skill required	3.89	3.33
Physical effort required	3.22	2.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.89	2.89
Outcome depends on the skill and judgment of physician	3.44	3.11
Estimated risk of malpractice suit with poor outcome	2.89	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.89	3.11
Intra-Service intensity/complexity	2.56	2.56
Post-Service intensity/complexity	3.44	2.67

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

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Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

  Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

  Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28555, we recommend 10.43 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28555 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

Code 28555 is more complex than one involving a metatarsophalangeal joint dislocation, but less complex than one involving a dislocation of a tarsometatarsal or talotarsal joint. The key reference code 28261 has 103 minutes of intra-service time while the survey code has 60. The survey code has 5 minutes more of pre-service time to evaluate the fracture. Both codes include an overnight hospital stay. Based on the potential post-operative complications, the consensus panel agrees that the number and type of visits are appropriate. The total time for the reference code is

higher (343) compared to the survey code (321). The median RVW of 12.00 is too high compared to the reference code and the 25th percentile of 10.43 is recommended.

Neurovascular injury and compartment syndrome may occur with this type of dislocation and multiple post-operative visits are necessary. Additionally, restoring proper functioning of the foot is essential. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion and weightbearing activities. X-rays would be reviewed. The second and third visits would be for splint or cast and dressing removal, wound evaluation, suture removal (2nd visit), new cast application, ROM exercises. Additionally, physical therapy recommendations would also be communicated (3rd visit). The fourth visit would be for cast removal and range of motion exercises and review of restrictions. X-rays would be reviewed. The fifth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 60% No 40%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 16% I do not agree 84%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 13% no change 84%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28555

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		75.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 75.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 60.0	Staff % of Physician time **Change: In Time** 15.00
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28585 Tracking Number F63 Specialty Society Recommended RVU: **12.00**
Global Period: 090 RUC Recommended RVU: **12.00**

CPT Descriptor: Open treatment of talotarsal joint dislocation, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old male sustains a talo-navicular dislocation requiring open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatio drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A dorsomedial longitudinal incision is made over the talo-navicular joint. Blunt dissection reveals the dislocation. The joint is manually reduced and temporarily fixated with a k-wire. Two screws are placed across the joint to provide fixation. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This require removing and reapplying the dressings.

Discharge day:
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28585					
Sample Size:	300	**Resp N:** 59	**Response:** 0.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	5.00	20.00
Survey RVW:		8.00	12.00	**15.00**	17.25	29.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	60.00	**75.00**	90.00	120.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**				

Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28585		
		Specialty Recommended
Physician Work RVU:		12.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		75.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	101.0	99211x 0.0 12x 2.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28299	090	11.39	RUC Time

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 25.4 %

TIME ESTIMATES (Median)

	CPT Code: 28585	Key Reference CPT Code: 28299	Source of Time RUC Time
Median Pre-Service Time	70.00	75.00	
Median Intra-Service Time	75.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	101.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**324.00**	**299.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.20
Urgency of medical decision making	3.83	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.67	3.60
Physical effort required	3.33	3.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.00
Outcome depends on the skill and judgment of physician	4.00	3.40
Estimated risk of malpractice suit with poor outcome	3.17	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.17	3.00
Intra-Service intensity/complexity	3.17	3.20
Post-Service intensity/complexity	3.67	3.00

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, th treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28585, we recommend 12.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28585 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The foot dislocation involved in 28585 is more complex than the other foot dislocations and fractures. This joint is more proximal and involves larger bones compared to a tarsometatarsal dislocation. Two bones are involved in this type of dislocation and the risk for post-operative complications is high. The survey code has 15 minutes less of intra-service time compared to the reference code (75 vs. 90) but the survey code has an overnight stay and five post-operative visits (99214 x 1, 99213 x 2, 99212 x 2) recommended while the reference code includes four post-operative visits (99213 x 3,

99212 x 1) only. The consensus panel also compared 28585 with similar work code 28615, which has a recommended RVW of 11.50.

Neurovascular injury and compartment syndrome may occur with this type of dislocation and the risk for complications is high. Close monitoring post-operatively is required and the restoration of foot function is essential so multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second and third visits would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast application, ROM exercises. The fourth visit would be for cast removal, range of motion exercises and review of restrictions. X-rays would be reviewed. Physical therapy recommendations would be communicated. The fifth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 47% No 53%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 14% I do not agree 86%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 11% no change 86%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28585

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		82.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 82.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		75.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 75.0	Staff % of Physician time **Change: In Time** 7.00
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28615 Tracking Number F64 Specialty Society Recommended RVU: **11.50**
Global Period: 090 RUC Recommended RVU: **11.50**

CPT Descriptor: Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male falls sustaining a first metatarsal cuneiform dislocation requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A dorsomedial longitudinal incision is made over the first metatarso-cuneiform joint. Blunt dissection reveals the dislocation. The joint is manually reduced and temporarily fixated with a k-wire. Two screws are placed across the joint to provide fixation. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- The patient is discharged to the orthopaedic floor for monitoring of compartment syndrome. This requires removing and reapplying the dressings.

Discharge day:
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.

- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report

Procedure note is written in the patient chart

- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28615					
Sample Size:	250	**Resp N:** 37	**Response:** 14.8 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**5.00**	10.00	30.00
Survey RVW:		8.50	11.50	**13.00**	14.50	25.00
Pre-Service Evaluation Time:				**35.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		15.00	41.00	**60.00**	74.00	120.00
Immediate Post Service-Time:	**18.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**134.0**	99211x **0.0** 12x **3.0** 13x **2.0** 14x **1.0** 15x **0.0**				

Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28615		
		Specialty Recommended
Physician Work RVU:		11.50
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	18.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	117.0	99211x 0.0 12x 3.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28299	090	11.39	RUC Time

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
66984	090	2,230,788	10.36	RUC Time

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

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
60220	090	10,859	12.29	RUC Time

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 21.6 %

TIME ESTIMATES (Median)

	CPT Code: 28615	Key Reference CPT Code: 28299	Source of Time RUC Time
Median Pre-Service Time	70.00	75.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	18.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	117.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**323.00**	**299.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.43
Urgency of medical decision making	3.75	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.75	3.57
Physical effort required	3.50	3.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.29
Outcome depends on the skill and judgment of physician	3.88	3.57
Estimated risk of malpractice suit with poor outcome	3.13	3.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	3.00
Intra-Service intensity/complexity	3.38	3.00
Post-Service intensity/complexity	3.38	2.71

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that it be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28615, we recommend 11.50 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28615 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

The dislocation involved in 28615 is complex because it involves two bones and the risk for complications is high. Treating this type of dislocation is more difficult than treating a dislocation involving a single bone and the recommended RVW is appropriately greater than 28555. The survey code has less intra-service time compared to the reference code (60 vs. 90) but more total time (325 vs. 299). An overnight stay is required due to the risk for complications, including compartment syndrome. Six post-operative visits are recommended (99214 x 1, 99213 x 2, 99212 x 3), compared to

four (99213 x 3, 99212 x 1) for the reference code. Restoration of foot function is essential and close monitoring of the patient post-operatively is required.

Neurovascular injury and compartment syndrome may occur with this type of dislocation and the risk for complications is high. Close monitoring post-operatively is required and the restoration of foot function is essential so multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, new splint or cast application, ROM exercises. The third and fourth visits would be for splint or cast and dressing removal, wound evaluation, suture removal (3rd visit), new cast application, ROM exercises. Physical therapy recommendations would be communicated. The fifth visit would be for cast removal, range of motion exercises and review of restrictions. X-rays would be reviewed. The sixth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 49% No 51%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 22% I do not agree 78%
B. Patients requiring this service are now:
   more complex (more work) 83% less complex (less work) 6% no change 11%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 22% no change 78%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28615

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.00	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 3.0	
		99213: 3.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28645 Tracking Number F65 Specialty Society Recommended RVU: **8.00**
Global Period: 090 RUC Recommended RVU: **8.00**

CPT Descriptor: Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male trips and sustains dislocation of his great toe metatarsophalangeal joint requiring an open reduction and internal fixation.

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulatior drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made over the metarsophalangeal joint of the great toe. Sharp and blunt dissection reveals the dislocation. The joint is manually reduced. Two K-wires are inserted across the joint to secure fixation. The dorsal extensor mechanism and tendon are repaired. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report

- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD					
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association					
CPT Code:	28645					
Sample Size:	250	**Resp N:** 37	**Response:** 14.8 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**4.00**	5.00	10.00
Survey RVW:		6.00	8.00	**9.00**	10.50	15.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		18.00	30.00	**45.00**	60.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**134.0**	99211x **0.0** 12x **3.0** 13x **2.0** 14x **1.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in th following table, and tab through to the key reference service box.

CPT Code: 28645		
		Specialty Recommended
Physician Work RVU:		8.00
Pre-Service Evaluation Time:		35.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		45.00
Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28292	090	8.72	RUC Time

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49505	090	105,266	7.88	RUC Time

CPT Descriptor 1 Repair initial inguinal hernia, age 5 years or over; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
14040	090	14,040	8.44	RUC Time

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 21.6 %

TIME ESTIMATES (Median)	CPT Code: 28645	Key Reference CPT Code: 28292	Source of Time RUC Time
Median Pre-Service Time	60.00	30.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	15.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	78.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**217.00**	**245.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.45	2.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.36	2.36
Urgency of medical decision making	2.55	2.09
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.45	2.55
Physical effort required	2.36	2.36
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.45	2.45
Outcome depends on the skill and judgment of physician	2.55	2.55
Estimated risk of malpractice suit with poor outcome	2.36	2.45

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.36	2.36
Intra-Service intensity/complexity	2.27	2.18
Post-Service intensity/complexity	2.45	2.36

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

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

- ***Evidence that technology has changed physician work.***

Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

Given this information, we believe there is compelling evidence that ORIF is more complex than 5 years ago and this is even more true in comparison to practice in the late 1980s (or more than 25 years ago).

- ***Evidence that incorrect assumptions were made in the previous valuation of the service; a misleading vignette and/or survey in a previous evaluation***

During the period of 1989-1991 (after the Harvard study), a major effort was undertaken by the AAOS and the OTA to rewrite every fracture and dislocation treatment code in the musculoskeletal Section of CPT. In 1991, 395 code changes were accepted by the AMA CPT Editorial Panel under the leadership of Dr. William Felts. At the time of the original proposal, some of the code descriptors were changed from those submitted (presumably by the CPT staff), and published in the 1992 and subsequent editions. Some of the changes in the descriptors published in CPT 1992 didn't make sense, but in those years, the CPT process was closed-door. Additionally, in 1992 and 1993 the AMA staff were deluged by the implementation of the RBRVS process and though AAOS and OTA requested that these problems be addressed then, AMA CPT staff asked that be deferred as their "plate was full." After that time, more important issues and other opportunities consumed the resources of the AAOS and inertia (or the lack thereof) took over. This third five year review, after completion of the practice expense review, allowed AAOS a window of time to again try to correct the nomenclature for these codes, and review their work using the standard RUC survey method.

We also note, that at the time of the original CPT proposal, external fixation was considered an adjunctive procedure. CPT instructed that the codes for external fixation (20690 and 20692) be "listed in addition to the code for the treatment ...of the fracture." This concept still applies today. External fixation can be used as an adjunctive stabilization modality when treating fractures by almost any method. However, external fixation can also be used in reconstructive orthopaedics (for example, the treatment of joint contractures) and for non-musculoskeletal system treatments (for example, as a suspension device in the treatment of lower extremity burns). In 1991, there was no Modifier -51 exempt code category. Today, these same codes, 20690 and 20692 for external fixator application are modifier -51 exempt, recognizing that they can stand alone or be used adjunctively. Because of the modifier -51 exemption, the RVUs have been reduced, so payers are not paying double when either of these codes are reported with another treatment code.

In the 2005 comment letter to CMS, the AAOS recommended examining the physician work for the ORIF codes because the code descriptors lacked clarity. In particular, because the CPT descriptors include the phrase "with or without internal or external fixation," it is difficult to imagine what the Harvard survey data actually represents (ie, no typical patient was described for the survey respondents to focus on). Further, after the descriptors for these codes were changed for CPT 1993, an Abt study was performed in 1992 for RUC consideration. This study produced *percentage* relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, we believe that there is little, if any, relationship between the Harvard database time and visit information (from the old CPT codes) and the current work RVUs.

Given this information, we believe there is compelling evidence that the current work values and/or time and visit data may be incorrect and outdated and should be reviewed.

- *Evidence that incorrect assumptions were made in the previous valuation of the service, as documented; a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data*

Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28645, we recommend 8.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28645 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This dislocation is less complex than one involving a tarsal bone, but more complex than one involving an interphalangeal joint. Survey respondents selected different reference codes. A consensus panel compared the code to 26715, which describes open treatment of a metacarpophalangeal dislocation and is a procedure that is similar to the survey code. The recommended RVW for 26715 is 7.95. The survey indicated six post-operative visits (99214 x 1, 99213 x 2, 99212 x 3) for 28645. A consensus panel reviewed the recommendations, agreed that six visits is too many,

and reduced the visits to four (99213 x 2 and 99212 x 2). The modified recommended visits are identical to those for 26715. Due to the survey code's similarity to code 26715, the consensus panel recommends the 25th percentile value of 8.00.

Neurovascular injury may occur with this type of dislocation and proper function of the joint must be restored so multir post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involv extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting or casting and instruction on range of motion (ROM) and weightbearing activities. X-rays would be reviewed. The second visit would be for splint or cast and dressing removal, wound evaluation, suture removal, new cast or splint application and ROM exercises. The third visit would be for splint or cast and dressing removal, wound evaluation, hardware removal, review of restrictions and ROM exercises. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 22% No 78%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 67% less complex (less work) 0% no change 22%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 33% no change 67%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28645

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		41.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 41.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 45.0	Staff % of Physician time **Change: In Time** 4.00
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:28675 Tracking Number F66 Specialty Society Recommended RVU: **6.00**
Global Period: 090 RUC Recommended RVU: **6.00**

CPT Descriptor: Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 11-year-old boy trips and sustains a dislocation of the interphalangeal joint of the second toe requiring open reduction and internal fixation.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- An ankle tourniquet is placed
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A longitudinal incision is made over the proximal interphalangeal joint of the second toe. The joint is manually reduced. A K-wire is first passed retrograde out of the tip of the toe, then anterograde into the proximal phalanx securing the reduction. The dorsal extensor mechanism and tendon are repaired. The wound is irrigated and closed in layers.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report

- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	R. Dale Blasier, MD, FACS Lloyd Smith, DPM Walter Pedowitz, MD, FACS Tye Ouzounian, MD William Creevy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons American Podiatric Medical Association American Orthopaedic Foot and Ankle Society Orthopaedic Trauma Association				
CPT Code:	28675				
Sample Size: 250	**Resp N:** 37	**Response:** 14.8 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**3.00**	5.00	15.00
Survey RVW:	4.00	6.00	**7.90**	8.50	15.00
Pre-Service Evaluation Time:			**30.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	15.00	30.00	**30.00**	5.00	90.00
Immediate Post Service-Time:	**18.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**118.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the key reference service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 28675		
		Specialty Recommended
Physician Work RVU:		**6.00**
Pre-Service Evaluation Time:		**30.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**15.0**
Intra-Service Time:		**30.00**
Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28288	090	5.81	RUC Time

CPT Descriptor Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99291	XXX	3,260,677	4.50	RUC Time

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
11646	010	10,371	6.21	RUC Time

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 29.7 %

TIME ESTIMATES (Median)

	CPT Code: 28675	Key Reference CPT Code: ____	Source of Time RUC Time
Median Pre-Service Time	55.00	20.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	99.00	
Median Office Visit Time	78.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**197.00**	**169.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.45	2.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.36	2.36
Urgency of medical decision making	2.55	2.09

Technical Skill/Physical Effort (Mean)

Technical skill required	2.45	2.55
Physical effort required	2.36	2.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.45	2.45
Outcome depends on the skill and judgment of physician	2.55	2.55
Estimated risk of malpractice suit with poor outcome	2.36	2.45

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.36	2.36
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Surgical treatment using open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as CT which allow better detection of the fracture pathology and provided the basis for new surgical strategies. There are also new internal fixation devices which require more work. Beginning in the 1990s (after the Harvard study), new plates were developed for fracture repair, with most becoming available in the late 1990s and early 2000s. As an example of the complexity of the decision process in current practice, the 1990's have given the surgeon numerous options for bone fixation. The options for a bone fixation device currently include Kirschner wires, wire, staples, screws, as well as newer alternatives such as headless bone screws, T-screws, absorbable pins, cannulated screws, and a myriad of plates. The goal of all these devices remains constant: that is, to achieve stable approximation of bone fragments to facilitate healing. The various devices afford rigid fixation along with compression of the osseous fragments. This allows early range of motion and preservation of surrounding joint function, as well as primary bone healing. Selection of the most advantageous form of fixation is dependent on many factors and takes considerable time in the pre-evaluation of a patient. These include the type of fracture or osteotomy created, bone density, type of bone, and the desire for interfragmental compression. All of this has resulted in more work. The standards of care (fracture reduction, limb alignment, etc.) have also been elevated by literature that shows fracture displacements and poor alignments lead to poorer results. Additionally, women over 50 is a fast growing segment of our population. A huge percentage of these patients are osteoporotic - making fracture fixation and maintenance of fixation far more difficult than it used to be. The new plates are more complex to insert when the underlying bone is of much poorer quality.

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Harvard utilized the AMA Physician Masterfile to draw names for their surveys. While general orthopaedic surgeons can perform open reduction fracture care, it is more typical for patients to be referred to orthopaedic surgeons who specialize in orthopaedic trauma or in a given anatomical area (eg, shoulder, hand, knee, etc.). We do not believe that all specialty surgeons were surveyed for these codes, since the AMA Masterfile did not delineate orthopaedic specialties. Additionally, podiatrists were not surveyed for any of the lower extremity codes.

Given this information, we believe there is compelling evidence that not all involved specialties were involved in the review of these codes.

A consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Society for Surgery of the Hand, Arthroscopy Association of North America, Orthopaedic Trauma Association, American Podiatric Medical Association, and American Orthopaedic Foot and Ankle Society met by conference call to discuss the survey data for the revised orthopaedic codes and data for the key reference codes and other codes on the survey reference service lists.

For revised code 28675, we recommend 6.00 work RVUs. After considering differences in time and visits, along with differences in intra-operative work, we believe this value correctly ranks code 28675 relative to other ORIF codes, relative to the key reference code, and relative to orthopaedic codes from the survey reference service list.

This procedure is less intense and requires less work than procedures involving either a tarsal or metatarsal bone. Compared to the reference service code of 28288, the intra-service time is identical at 30 minutes but the survey code has more pre-service time since the survey code involves a dislocation requiring fixation, which requires more positioning and prep time. The reference code does not require fixation. The reference code has five post-operative visits (99213 x 4, 99211 x 1) and five post-operative visits were indicated by the survey (99214 x 1, 99213 x 2, 99212 x 2). However,

based on the recommendations of a consensus panel, the 99214 visit was removed for the final recommendations as four post-operative visits are appropriate. The total time for the survey code is higher (197) compared to the reference code (169). Due to the trauma involved with this type of dislocation, the risk for post-operative complications remains.

Neurovascular injury may occur with this type of dislocation and multiple post-operative visits are necessary. Assessment of the circulation, sensation and motor function of the involved digit and extremity is ongoing. The first office visit would include removal of the splint and dressing, wound evaluation, redressing, discussion of restrictions and operative findings, splinting and instruction on weightbearing activities. X-rays would be reviewed. The second visit would be for splint and dressing removal, wound evaluation, suture removal, new splint application, and instruction on range of motion (ROM) exercises. The third visit would be for splint removal, removal of hardware, range of motion exercises and review of restrictions. X-rays would be reviewed. The fourth visit would be to check X-rays, wound healing and ROM.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

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

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):
Has the work of performing this service changed in the past 5 years? Yes 22% No 78%
(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 67% less complex (less work) 0% no change 22%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 33% no change 67%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 28675

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		34.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 34.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 30	Staff % of Physician time **Change: In Time** 4.00
Clinical Staff #2	Staff Type: N/A	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

Attestation Statement

2005 UTIL	Surveyed or Reference	CPT	DESC	2007 RVW	SPEC REC	IWPUT	NOTES	RUC NEW	RUC NEW	Total Time	Hosp Vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP (992-) P-SD	POST-HOSP (992-) 32	POST-HOSP (992-) 31	POST-HOSP (992-) 38	POST-OFF (992-) 15	POST-OFF (992-) 14	POST-OFF (992-) 13	POST-OFF (992-) 12	POST-OFF (992-) 11
5,098,625	MPC	99203	Office or other o	1.34	1.34	0.057		1.34	0.057	29	0.0	0.0	4			20	5								
3,228,657	MPC	99204	Office or other o	2.30	2.30	0.065		2.30	0.065	45	0.0	0.0	5			30	10								
16,274	RSL	26600	Closed treatmen	2.48	2.48	0.024		2.48	0.024	93	0.0	4.0	7	2		15	5							4	
3,260,677	MPC	99291	Critical care, eva	4.50	4.50	0.096		4.50	0.096	70	0.0	0.0	15			40	15								
107,426	MPC	64721	Neuroplasty and	4.84	4.84	0.024		4.84	0.024	171	0.5	3.0	20	15	10	25	20			0.5			2	1	
74	RSL	25651	Percutaneous sk	5.68	5.68	0.040		5.68	0.040	190	0.5	4.0	50			30	20			0.5			1	3	
161	survey	26650	Percutaneous sk	5.80	6.00	0.040		6.00	0.040	197	0.5	4.0	30	10	10	30	20			0.5			2	2	
3,621	RSL	28288	Ostectomy, parti	5.81	5.81	0.035		5.81	0.035	169	0.0	5.0	20			30	20						4		1
51,489	RSL	20680	Removal of impl	5.90	5.90	0.056		5.90	0.056	181	0.5	2.0	35	15	15	50	15			0.5				2	
142	survey	28675	Open treatment	2.97	6.00	0.042		6.00	0.042	197	0.5	4.0	30	10	15	30	15			0.5			2	2	
280	survey	28525	Open treatment	3.37	6.00	0.035		6.00	0.035	207	0.5	4.0	35	10	15	30	20			0.5			2	2	
10,371	MPC	11646	Excision, malign	6.21	6.21	0.069		6.21	0.069	128	0.0	1.0	20	5	5	65	10						1		
84	RSL	25671	Percutaneous sk	6.32	6.32	0.038		6.32	0.038	210	0.5	4.0	50			45	25			0.5			1	3	
1,873	survey	26765	Open treatment	4.21	6.60	0.037		6.60	0.037	217	0.5	4.0	35	10	10	45	20			0.5			2	2	
NEW '07	RSL	25109	Excision of tend	6.81	6.81	0.063		6.81	0.063	191	0.5	3.0	25	10	15	40	20			0.5			2	1	
517	survey	26785	Open treatment	4.25	7.45	0.053		7.45	0.053	227	0.5	4.0	40	10	15	45	20			0.5			2	2	
21	RSL	24332	Tenolysis, tricep	7.77	7.77	0.051		7.77	0.051	230	0.5	4.0	50			60	30			0.5			1	3	
105,266	MPC	49505	Repair initial ing	7.88	7.88	0.065		7.88	0.065	198	0.5	2.0	20	15	15	70	20			0.5			1	1	
152	RSL	25652	Open treatment	7.92	7.92	0.056		7.92	0.056	225	0.5	4.0	50			60	25			0.5			1	3	
249	survey	26715	Open treatment	5.79	7.95	0.073		7.95	0.073	220	0.5	4.0	38	10	15	40	20			0.5			2	2	
1,343	survey	26615	Open treatment	5.38	8.00	0.069		8.00	0.069	217	0.5	4.0	35	10	10	45	20			0.5			2	2	
1,001	survey	28645	Open treatment	4.27	8.00	0.070		8.00	0.070	217	0.5	4.0	35	10	15	45	15			0.5			2	2	
57	survey	26685	Open treatment	7.09	8.00	0.053		8.00	0.053	227	0.5	4.0	30	10	10	60	20			0.5			2	2	
448	survey	28505	Open treatment	3.86		0.072				227	0.5	4.0	40	10	15	45	20			0.5			2	2	
1,963	survey	28485	Open treatment	5.77	8.00	0.049		8.00	0.049	242	0.5	4.0	40	10	15	60	20			0.5			2	2	
2,885	RSL	28289	Hallux rigidus co	8.11	8.11	0.069		8.11	0.069	197	0.0	4.0	30			45	30						4		
15,070	MPC	43269	Endoscopic retro	8.20	8.20	0.093		8.20	0.093	141	0.0	0.0	40			71	30								
4,575	RSL	28750	Arthrodesis, grea	8.37	8.37	0.042		8.37	0.042	237	0.0	4.0	40			75	30						4		
1,692	survey	26735	Open treatment	6.03	8.40	0.056		8.40	0.056	237	0.5	4.0	40	10	10	60	20			0.5			2	2	
76,932	MPC	14040	Adjacent tissue	8.44	8.44	0.050		8.44	0.050	223	0.0	4.0	15	10	5	90	25						2	2	
1,547	survey	27766	Open treatment	8.73	8.50	0.045		8.60	0.045	266	2.0	4.0	40	10	15	45	20		1	1.0			2	2	
13,149	RSL	28292	Correction, hallu	8.72	8.72	0.042		8.72	0.042	245	1.0	4.0	30			60	25			1.0			4		
32,582	RSL	29824	Arthroscopy, sho	8.82	8.82	0.065		8.82	0.065	225	0.5	4.0	48			60	20			0.5			2	2	
85	survey	26665	Open treatment	7.72	9.00	0.067		9.00	0.067	237	0.5	4.0	35	10	15	60	20			0.5			2	2	
1,260	survey	25545	Open treatment	9.09	9.00	0.039		9.00	0.039	286	2.0	4.0	40	10	10	60	30		1	1.0			2	2	
91,000	MPC	14060	Adjacent tissue	9.07	9.07	0.090		9.07	0.090	183	0.0	4.0	15	10	5	60	15						2	2	
NEW '07	RSL	25607	Open treatment	9.35	9.35	0.052		9.35	0.052	275	0.5	5.0	40	10	15	60	30			0.5			3	2	
6,720	survey	24685	Open treatment	8.92	9.50	0.069		9.50	0.069	252	0.5	4.0	40	15	10	60	30			0.5			2	2	
209	survey	28465	Open treatment	7.13		0.085				257	0.5	4.0	45	10	15	60	30			0.5			2	2	
2,218	survey	27829	Open treatment	5.68	9.50	0.096	Survey da	9.50		271	2.0	4.0	45	10	15	45	20						2	2	
52,156	MPC	50590	Lithotripsy, extra	9.64	9.64	0.080		9.64	0.080	234	0.5	3.0	35	15	13	60	30			0.5			2	1	
4,368	RSL	25115	Radical excision	9.89	9.89	0.050		9.89	0.050	257	0.0	4.0	45			90	30						4		
661	survey	25515	Open treatment	9.37	10.00	0.079		10.00	0.079	247	0.5	4.0	40	10	10	60	30			0.5			2	2	
676	survey	24635	Open treatment	13.56	10.00	0.055		10.00	0.055	291	2.0	4.0	40	10	15	60	30		1	1.0			2	2	
370	survey	25574	Open treatment	7.47	10.00	0.053		10.00	0.053	296	2.0	4.0	45	10	15	60	30		1	1.0			2	2	
2,230,788	MPC	66984	Extracapsular ca	10.36	10.36	0.211		10.36	0.211	162	0.5	4.0	10	5	10	30	10			0.5			2	2	
146	survey	28555	Open treatment	6.42	10.43	0.066	The numb			281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
316	survey	27784	Open treatment	7.41	10.45	0.066		10.45	0.066	281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
5,492	survey	27792	Open treatment	7.91	10.50	0.067		10.50	0.067	281	2.0	4.0	40	10	15	60	20		1	1.0			2	2	
NEW '07	RSL	25608	Open treatment	10.86	10.86	0.052		10.86	0.052	305	0.5	5.0	40	10	15	90	30			0.5			3	2	
268	survey	25628	Open treatment	9.50	11.00	0.065		11.00	0.065	277	0.5	4.0	45	10	15	90	20			0.5			2	2	
660	survey	23515	Open treatment	7.47	11.00	0.062		11.00	0.062	287	0.5	4.0	40	15	15	90	30			0.5			2	2	
9	survey	27832	Open treatment	6.87	11.00	0.059		11.00	0.059	301	2.0	4.0	45	10	15	75	20		1	1.0			2	2	
195	survey	24575	Open treatment	11.02	11.00	0.060		11.00	0.060	308	2.0	4.0	45	15	15	60	30		1	1.0			3	1	

2005 UTIL	Surveyed or Reference	CPT	DESC	2007 RVW	SPEC REC	IWPUT	NOTES	RUC NEW	RUC NEW	Total Time	Hosp Vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP (992-) P-SD	32	31	38	POST-OFF (992-) 15	14	13	12	11
933	survey	26746	Open treatment	5.86	11.10	0.058		11.10	0.058	303	0.5	5.0	45	10	15	83	30			0.5			3	2	
3,398	MPC	28299	Correction, hallu	11.39	11.39	0.058		11.39	0.058	299	0.5	4.0	75			90	30			0.5			3	1	
873	survey	28615	Open treatment	8.96	11.50	0.056	The numb	11.50		323	2.0	6.0		10		60	18		1	1.0				3	
13,957	survey	27814	Open treatment	11.10		0.075				346	2.0	4.0	45	10	15	90	30	1		1.0			2	2	
239	survey	25525	Open treatment	12.69	12.00	0.064	The numb	12.00		303	2.0	4.0	45	10	15	70	20		1	1.0				1	
971	survey	23630	Open treatment	7.47	12.00	0.070		12.00	0.070	306	2.0	4.0	43	15	15	70	20		1	1.0			3	1	
203	survey	28585	Open treatment	8.17	12.00	0.053	The numb	12.00		324	2.0	5.0	45	10	15	75	20		1	1.0				2	
208	survey	27826	Open treatment	8.97		0.091	The numb			328	2.0	4.0	45	15	15	60	30	1		1.0				1	
10,859	MPC	60220	Total thyroid lob	12.29	12.29	0.077		12.29	0.077	275	2.0	2.0	63			90	25		1	1.0			1	1	
152	RSL	28261	Capsulotomy, m	12.91	12.91	0.050		12.91	0.050	343	2.0	4.0	60			103	30		1	1.0			4		
636	survey	24579	Open treatment	11.96	13.00	0.062		13.00	0.062	338	2.0	4.0	45	15	15	90	30		1	1.0			3	1	
239	survey	23670	Open treatment	8.02	14.00	0.080		14.00	0.080	326	2.0	4.0	40	15	15	90	30		1	1.0			2	2	
7,914	survey	23615	Open treatment	10.93		0.085				338	2.0	4.0	45	15	15	90	30		1	1.0			3	1	
1,337	survey	25575	Open treatment	12.02	14.00	0.059	The numb	14.00		342	2.0	5.0	45	10	15	90	30		1	1.0					
NEW '07	RSL	25609	Open treatment	14.12	14.12	0.058		14.12	0.058	358	0.5	6.0	40	10	15	120	30			0.5			4	2	
7,278	survey	27822	Open treatment		14.75	0.076			0.047	353	2.0	4.0	45	10	15	90	30	1		1.0			3	1	
25,915	RSL	23420	Reconstruction o	14.75	14.75	0.054		14.75	0.054	368	2.0	5.0	45			120	30		1	1.0			5		
197	survey	23680	Open treatment	10.30	15.00	0.067		15.00	0.067	361	2.0	4.0	45	15	15	120	30		1	1.0			2	2	
1,426	survey	24545	Open treatment	10.88	15.00	0.067		15.00	0.067	361	2.0	4.0	40	20	15	120	30		1	1.0			2	2	
1,384	survey	27823	Open treatment			0.072			0.064	366	2.0	4.0	45	15	15	98	30	1		1.0			3	1	
130	survey	25526	Open treatment	13.43	15.00	0.055	The numb	15.00		367	2.0	5.0	45	10	15	115	30		1	1.0					
31,681	RSL	29827	Arthroscopy, sho	15.44	15.44	0.083		15.44	0.083	334	0.5	5.0	75			120	40			0.5				5	
863	survey	27827	Open treatment	15.75		0.080	The numb			441	3.0	5.0	55	15	15	120	30	1	1	1.0				1	
355	survey	23585	Open treatment	9.15	16.25	0.067		16.25	0.067	407	3.0	4.0	60	23	15	120	33		2	1.0			2	2	
1,163	MPC	65750	Keratoplasty (co	16.60	16.60	0.108		16.60	0.108	288	0.0	6.0	40			90	20						6		
1,331	survey	24546	Open treatment	15.99		0.083	The numb			448	3.0	4.0	50	20	15	150	30	1	1	1.0				1	
33,064	MPC	58150	Total abdominal	17.21	17.21	0.071		17.21	0.071	394	5.0	2.0	45	5	10	120	30	1	3	1.0			2		
218	RSL	27709	Osteotomy; tibia	17.32	17.32	0.093		17.32	0.093	347	3.0	4.0	40	18	10	108	15		2	1.0			2	2	
101,683	RSL	27236	Open treatment	17.43	17.43	0.060		17.43	0.060	473	6.0	4.0	60	15	15	90	30	2	3	1.0			3	1	
999	survey	28415	Open treatment	17.54		0.080	The numb			441	3.0	5.0	55	15	15	120	30	1	1	1.0				1	
55	survey	28420	Open treatment	17.07		0.086	The numb			481	3.0	5.0	60	20	15	150	30	1	1	1.0				1	
6,992	MPC	37215	Transcatheter pl	19.58	19.58	0.122		19.58	0.122	347	2.0	2.0	60	15	15	103	30	1		1.0			2		
1,118	survey	27828	Open treatment	18.19		0.091	The numb			471	3.0	5.0	55	15	15	150	30	1	1	1.0				1	
412	RSL	28705	Arthrodesis; pan	20.12	20.12	0.058		20.12	0.058	490	3.0	4.0	75			180	35	1	1	1.0		1	2	1	
4,678	survey	23616	Open treatment	21.68	21.00	0.097	The numb	21.00		413	3.0	4.0	50	15	15	120	30	1	1	1.0				1	
370	survey	28445	Open treatment			0.092			0.059	444	3.0	5.0	58	15	15	120	30	1	1	1.0				1	
2,260	MPC	50546	Laparoscopy, su	21.69	21.69	0.064		21.69	0.064	467	4.0	3.0	60			205	18		3	1.0		1	2		
16,470	RSL	23472	Arthroplasty, gle	22.47	22.47	0.079		22.47	0.079	458	4.0	4.0	60			165	30	1	2	1.0			3	1	
382,332	RSL	27447	Arthroplasty, kne	23.04	23.04	0.099		23.04	0.099	469	5.0	4.0	45	15	15	124	30	1	3	1.0		1	2	1	
996	MPC	63051	Laminoplasty, ce	25.38	25.38	0.086		25.38	0.086	495	4.0	3.0	55	25	15	190	30	1	2	1.0			2	1	
11,399	MPC	44204	Laparoscopy, su	26.29	26.29	0.097		26.29	0.097	455	5.0	3.0	45			180	30	1	3	1.0			2	1	
18,866	RSL	27487	Revision of total	26.91	26.91	0.081		26.91	0.081	520	6.0	4.0	60			200	30		5	1.0			4		

RUC Recommendations for CPT 2008 Volume II

RUC Meetings September 2006, February 2007 and April 2007

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2008

TABLE OF CONTENTS
Volume I

Anesthesia for Radiologic Spine Procedures	1
Soft Tissue Brachytherapy Implant Placement	2
Application of Cranial Tongs	3
External Fixation	4
Computer Navigation	5
Temporomandibular Joint Manipulation	6
Interstitial Fiducial Marker Placement	7
Three Column Osteotomy	8
Internal or External Fixation – Shoulder/Elbow	9
Epicondylitis Procedures	10
Internal or External Fixation – Elbow/Hand	11
Femoral Head Fracture Treatment	12
Internal or External Fixation – Hip/Knee	13
Open Knee Osteochondral Autograft	14
Posterior Malleolar Fracture Treatment	15
Fibula Malunion	16
Internal or External Fixation – Foot/Ankle	17

Volume II

Open Osteochondral Talus Graft	18
Arthroscopic Biceps Tenodesis	19

Subtalar Arthroscopy	20
Insert Emergency Airway	21
Add-On Maze	22
Valve Sparing Aortic Annulus Reconstruction	23
Wireless Pressure Sensor Implantation and Study	24
Brachial-Ulnar Bypass Graft	25
Non-Implantable Venous Access Device Blood Draws	26
Arterial Catheterization	27
Head and Neck Interstitial Brachytherapy Needle or Catheter Placement	28
Peritoneal Tumor Ablation	29
G-, J-, G-J, C-Tube Procedures	30
Transuretheral Ureteral Stent Tube Exchange and Removal	31
Intra-Abdominal Voiding Pressure	A
Pelvic Interstitial Brachytherapy Needle or Catheter Placement	B
Percutaneous Renal Tumor Cryotherapy	C
Prostate Laser Enucleation	D
Laparoscopic Paravaginal Defect Repair	E
Laparoscopic Total Hysterectomy	F
Viterectomy with Epiretinal Membrane Stripping	G
Retinopathy Treatment	H
Nasolacrimal Duct Balloon Catheter Dilation	I
Cardiac MRI	J
Brain and Cerebrospinal Fluid Imaging	K

PET Imaging	L
Manual Microdisection	M
Immune Globulin Subcutaneous Infusion	N
Insertion and Placement of Heart Catheter	O
Allergy Test Interpretation	P
Electronic Analysis of Implanted Neurostimulator Pulse Generator System	Q
Ocular Photoscreening	R
Initial Day Hospital Neonate Care	S
Team Conference	T
Non-Face-to-Face Physician Services	U
Smoking Cessation	V
Alcohol, Drug Screening and Brief Intervention	W

AMA
AMERICAN MEDICAL ASSOCIATION

May 30, 2007

Leslie Norwalk
Acting Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Norwalk:

It is with pleasure that I submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), work relative value and direct practice expense input recommendations for new and revised codes for CPT 2008. In addition, I submit the work relative value and direct practice expense input recommendations for codes identified in the third Five-Year Review. At this time, the RUC is also submitting physician time data corrections and updates for existing services as well as comments regarding specific payment policies for consideration in the 2008 Medicare Physician Payment Schedule *Proposed Rule*. The RUC Health Care Professionals Advisory Committee Review Board is separately forwarding its recommendations to CMS.

Cost estimates for medical supplies and equipment not listed on "CMS's Labor, Supply, and Equipment List for the Year 2007" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity or cash discounts, prices for used equipment or any other factors which may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment.

CPT 2008 New and Revised Codes

Enclosed are two binders of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2008 is 332, including 118 additions, 186 revisions and 28 deletions. Thirty of these new and revised codes are not payable on the RBRVS (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes. In addition, seven of these new codes were reviewed by the RUC HCPAC Review Board as these codes describe services provided by non-MD/DO health professionals. Of the remaining 267 new and revised codes, the RUC submits 266 recommendations at this time. The RUC does not submit a recommendation for code 99174 *Ocular photoscreening with interpretation and report, bilateral*, due to a lack of specialty interest in developing recommendations.

The RUC is recommending that eleven codes be carrier priced in 2008. In addition, the RUC recommends interim values for 15 codes. The summary table in the attached binders and in the enclosed CD, specifically identifies the G-, J-, G-J, C-Tube Procedures (49441-49465 and 43760), Femoral Head Fracture (27267-27269) and Computer Navigation (20985-20987) to be re-reviewed at the September 2007 RUC Meeting. I will send any new information related to these services to CMS immediately following the meeting.

Also included in these binders and on the enclosed CD, are physician time data for each of the CPT codes reviewed at the September 2006, February 2007 and April 2007 RUC meetings. The RUC continues to review physician time data to ensure that the most accurate data is utilized in the CMS practice expense methodology.

2005 Five-Year Review Issues

Enclosed in a separate binder are recommendations for nine issues identified for review in the most previous Five-Year Review. These issues include:

- Partial Mastectomy (19301)
- Insertion of Heart Pacemaker (33207)
- Anoscopy and Proctosigmoidoscopy (45300, 45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321, 45327, 46600, 46604, 46606, 46608, 46610, 46611, 46612, 46614, 46615)
- Eye Exams (92002-92014)
- Audiology and Speech-Language Pathology Services (92557, 92567, 92568, 92569, 92579, 92601, 92602, 92603, 92604)
- Doppler Color Flow (93325)
- Nursing Facility Care (99304-99318)
- Domiciliary Care (99326-99328, 99334-99337)
- Home Care (99343-99345, 99347-99350)

Also included with these recommendations are physician time data for each of the Five-Year Review issues discussed.

CMS Requested Review of Practice Expense Inputs

Enclosed are direct practice expense refinement recommendations for eight issues as requested by CMS and reviewed at the February and April 2007 meetings of the RUC.

The issues include:

- Transcatheter Placement of Intravascular Stent(s) (37205, 37206, 75960)
- OB/GYN Procedures – Supply Pack (All OB/GYN Procedures)
- Gynecologic Oncology (All GYN/ONC Procedures)
- Computer Aided Detection (CAD) Breast Mammography (77051, 77052)
- Dual-Energy X-Ray Absorptiometry (77080-77082)
- Proton Beam Treatment Delivery (77520-77525)
- Remote Afterloading High Intensity Brachytherapy (77781-77784)
- Cardiac Catheterization (93501-93572)

Other RUC Recommendations

As CMS develops the Proposed Rule for the 2008 Physician Payment Schedule, I ask that you consider several pending RUC recommendations.

Anesthesia Recommendations
CMS requested a RUC review of anesthesia services in the *Final Rule* published in the December 1, 2006 *Federal Register*. CMS stated that, "Although anesthesia services are paid under the Physician Fee Schedule, they are paid on the basis of an anesthesia code-specific base unit and time units that vary based on the anesthesia time of the case. Since anesthesia services do not have a work values per codes as do other medical services, a work value must be imputed for each anesthesia code. As a result of its relationship with the RUC and the past recommendations for valuing anesthesia services, which were discussed in detail in the June 29, 2006 Proposed Notice, the American Society of Anesthesiologists (ASA) requested that we address the valuation of anesthesia services reported under CPT code 00100 through 01999. The ASA furnished an analysis that builds on the methodology used in the last 5 Year Review for the valuation of work for anesthesia services. We recommend that the valuation of anesthesia services, namely the proposed valuation of the post-induction time, be referred to the AMA RUC for review and consideration."

To address this request the RUC formed the Anesthesia Workgroup which reviewed this issue at length during two conference calls and three face-to-face meetings. Based on the extensive review of all the building block components and validation of Post-Induction

Period Procedure Anesthesia (PIPPA) work by surgeons on the Workgroup familiar with anesthesia services associated with their specialty, the Workgroup reached unanimous agreement that the revised model predicts anesthesia undervaluation. **The RUC recommends to CMS that Anesthesia work is undervalued by 32%.**

The RUC also identified three anesthesia services that may be misvalued based on this analysis and recommend that CMS allow review of the base units for at an upcoming RUC meeting:

00142 ***Anesthesia for procedures on eye; lens surgery****
00210 ***Anesthesia for intracranial procedures; not otherwise specified****
00562 ***Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator****

**Assumed to be overvalued, base unit too high or incorrect quintile assumption in the second Five-Year Review valuation.*

Supporting documents including the specific recommendations made by the Anesthesia Workgroup, the anesthesia quintile intensity retrofit calculations, the anesthesia regression versus quintile comparison, and the final anesthesia services calculations using the building block methodology as approved by the RUC, are enclosed in the Other RUC Recommendations Binder.

Budget Neutrality – Work Adjuster
The Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. To limit the increases in Medicare expenditures as mandated by the statute, CMS has applied a new "work adjuster" to ensure budget neutrality following the implementation of the improved work RVUs from the most recent Five-Year Review of the RBRVS. **The RUC argues that applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward and strongly urges CMS to apply the necessary adjustments to the conversion factor.**

From 1998 to present, CMS has implemented all work neutrality adjustments by adjusting the Medicare conversion factor. CMS did not explain why it altered this long utilized method and moved backward to an approach that the agency itself remarked was inappropriate. The RUC requests that CMS consider the history and these additional arguments and apply budget neutrality to the conversion factor:

1.) Adjusting the conversion factor does not affect the relativity of services reflected in the recommended RVUs. Adjusting the RVUs has the potential to inappropriately affect relativity and dampen the improvements to the E/M services valuation. CMS has publicly lauded the RUC for recommending these increases to E/M and we would surmise that the agency would want to achieve the full benefit of these improvements.

2.) An adjustment in the Medicare conversion factor is preferable because it has less impact on other payers who use the Medicare RVUs. That is, an adjustment in the Medicare conversion factor will not necessarily affect the payment rates of other payers who use the Medicare RVUs and their own conversion factors. However, any adjustment in the RVUs will impact the payment rates of such payers. The payment rates of payers who peg their rates to a percentage of Medicare will be affected regardless. The RUC believes that CMS must consider such "ripple effects" as it decides how to adjust for work neutrality.

3.) The RUC believes an adjustment to the conversion factor recognizes that budget neutrality is mandated for monetary reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality

4.) Applying the work neutrality adjustment to the conversion factor would coincide with CMS' current mission of making Medicare payment transparent.

Equipment Assumptions – Equipment Utilization Data
CMS currently utilizes an interest rate of 11% in pricing medical equipment. CMS has acknowledged that this rate is too high and requested comments regarding the appropriate interest rate. The RUC also discussed and agreed that the interest rate currently utilized is too high. The RUC agreed that the interest rate should fluctuate according to market conditions, rather than a fixed rate. The cost of capital is a legitimate expense of a physician's office and should be linked to prevailing rates. **CMS should adjust the 11% cost of capital rate to a market competitive rate.**

Equipment Assumptions – Cost of Capital Assumptions
CMS requested information on how it should reflect the utilization rate, particularly for high cost equipment. Currently, CMS uses a 50% utilization rate for all equipment. The RUC has discussed whether there should be a different rate for all equipment or just for the equipment set by specific cost thresholds. The RUC indicated that the cost of capital may not have a direct linear relationship with equipment utilization. Further, the RUC discussed whether consideration should be given to impacts on rural payment, as utilization rates may not be as high as in urban areas. The RUC recommends that the existing CMS standard of 50% utilization rate for all equipment is not an accurate measure. **CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations.**

Practice Expense Inputs - Supplies
The Practice Expense Subcommittee and the RUC in an effort to continually refine the RUC's process of developing practice expense recommendations agreed that some

mechanism should be in place to distinguish high priced disposables medical supplies, from the practice expense methodology so that the inequities of the scaling factors do not cause as many anomalies in the practice expense specialty pools and in practice expense relative values. The RUC recommends:

CMS set a specific reasonable threshold for the creation of J codes on high priced disposable medical supplies, and that an impact analysis be performed to find out how individual specialty's and practice expense pools would be affected. In addition, medical supplies used in the practice expense methodology, priced at or above $200, should be re-priced on an annual basis.

Members of the subcommittee believed that an initial reasonable threshold could be $250.00.

Professional Liability Insurance
In 1999, and consistently since 2004, the RUC has urged CMS to address a significant problem in the PLI RVU determinations for services with a technical component and professional component. The current CMS methodology generates a higher PLI relative value for the technical component portion than the professional component. One particularly poignant example of this inverse relationship is found in 77057, *Screening mammography, bilateral (2-view film study of each breast)* For this service, carrying a considerable amount of risk in screening for cancer, the PLI RVU for the professional component is .03, while the technical component is .07. The professional component PLI RVU includes the interpretation of results and the most significant amount of liability, but is valued less than half of the technical component PLI RVU, which accounts for only the risk posed by the equipment and the imaging process.

In the Final Rule for the 2005 Physician Payment Schedule, CMS responded to the continuing RUC comments as follows:

> *Physician work RVUs are used to adjust for risk of service. Because technical component services do not have physician work RVUs, they are still valued using charge-based RVUs instead of the resource-based malpractice RVU methodology. We look forward working with the ACR and the other interested specialty organizations to examine alternative methodologies that would allow technical component services to also reflect resource-based malpractice RVUs.*

At a minimum, CMS should appropriately reallocate PLI RVUs within the physician fee schedule by accepting the RUC interim recommendation to establish the technical component PLI RVU to be equivalent to the professional component PLI RVU for each

CPT code. **A more appropriate strategy would develop a methodology to ensure that the technical component PLI RVUs reflect resource-based professional liability costs.**

CMS Definition of Pre-time
The RUC requests that CMS consider a modification to the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology. The current CMS definition of pre-service time for physicians is as follows:

Pre-service period
The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- *Hospital admission work-up.*
- *The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.*
- *Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other "non-skin-to-skin" work in the OR.*

The following services are ***not included****:*

- *Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).*
- *Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).*
- *Mandated services (reported with modifier -32).*

The RUC recommends that the physician pre-service period instead begin when the decision for surgery is made. Physicians may engage in many of these pre-service activities (eg, review of records, communicating with other professionals, etc) prior to the day before the operative procedure.

<u>Five Year Review Identification Workgroup and New Technology/Services Identification/Review Process</u>

Based on previous MedPAC discussions and recommendations to Congress, CMS led initiatives to identify misvalued services, and its own mission to ensure correct valuation of all codes, the RUC concurred that there should be a process to identify such codes.

This workgroup initially convened in October 2006 and February 2007. Through this process, the RUC has begun to identify services incorporating new technology, which are likely to change in value, for subsequent review in order to minimize future misvaluation. The RUC is also developing other objective measures to identify misvalued services.

At its April 2006 meeting, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. First, a code is identified as a new technology/service at the RUC meeting in which it is initially reviewed. Second, the code is identified as a new technology/service in the next version of the RUC database with the date it is to be re-reviewed. Third, the code will be reviewed according to this schedule (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available. A flow chart providing a detailed description of this process is below. The RUC has already identified 78 of these procedures through its new and revised process. A table of these codes identified as new technology/services has been attached.

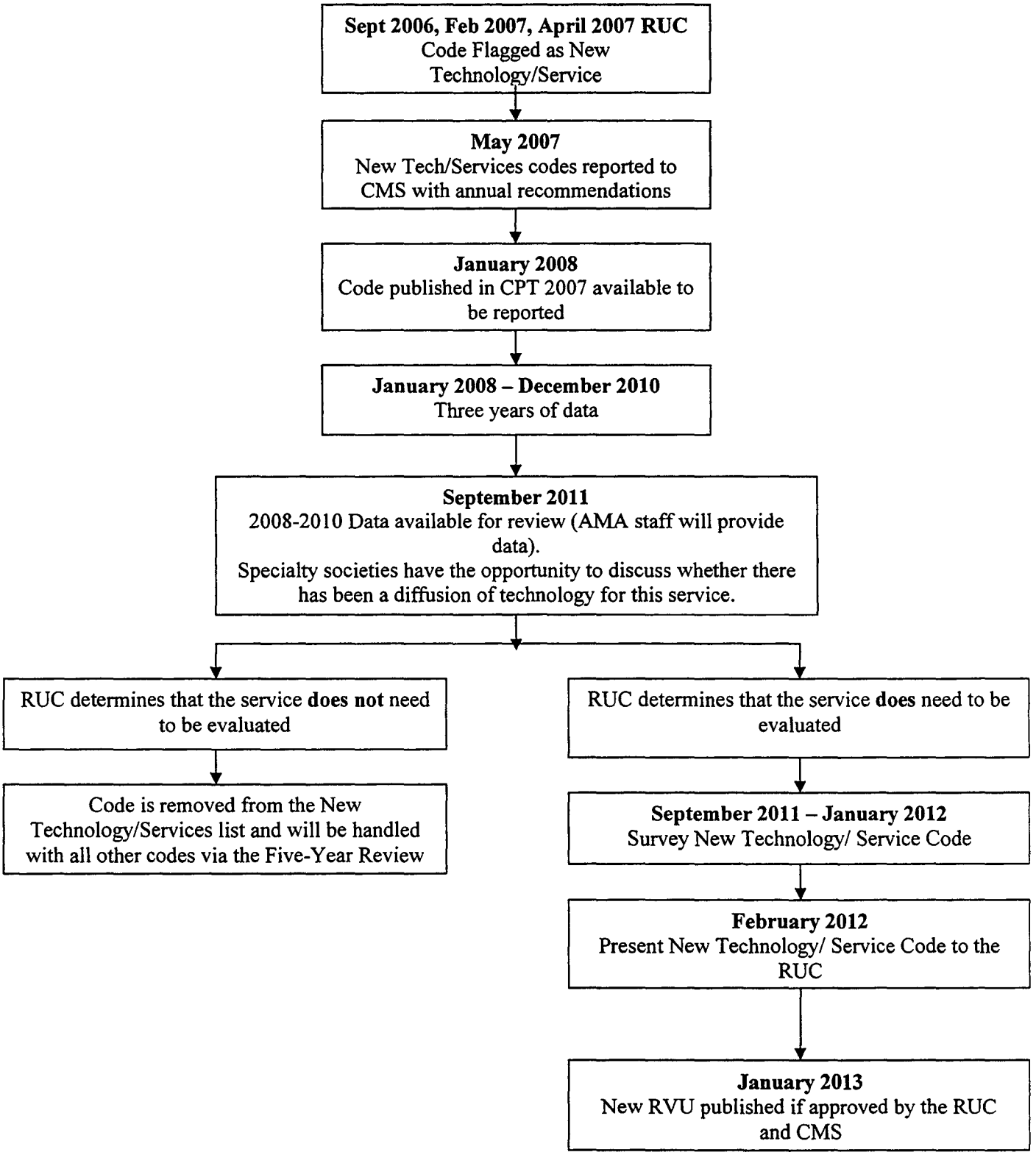
We appreciate your consideration of the RUC's recommendations. You may contact Sherry Smith at the AMA with any questions regarding this submission

Sincerely,

William L. Rich, III, MD, FACS

cc: Gaysha Brooks
Rick Ensor
Edith L. Hambrick, MD
James Hart
Ken Simon, MD
Sherry Smith
Pam West, PT
RUC Participants

Chart: Flow Chart of RUC Process to Identify/Review New Technology/Services



CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr-06	Fibroadenoma Cryoablation	11	September 2010	CPT 2007
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr-06	Percutaneous Intradiscal Annuloplast	13	September 2010	CPT 2007
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels	Apr-06	Percutaneous Intradiscal Annuloplast	13	September 2010	CPT 2007
22857	Total disc arthroplasty (artificial disc), including anterior approach, including diskectomy to prepare interspace (other	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
22862	Revision including replacement of total disc arthroplasty (artificial disc) including anterior approach, lumbar, single	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
22865	Removal of total disc arthroplasty (artificial disc), including anterior approach, lumbar, single interspace	Feb-06	Lumbar Arthroplasty	8	September 2010	CPT 2007
32998	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleur or chest wall when involved	Apr-06	Percutaneous RF Pulmonary Tumor Ablation	15	September 2010	CPT 2007
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	September 2010	CPT 2007
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
43648	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum; revision or removal of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	September 2010	CPT 2007
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	Feb-06	Laparoscopic Supracervical Hysterectomy	13	September 2010	CPT 2007
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb-06	Functional MRI	15	September 2010	CPT 2007
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb-06	Functional MRI	15	September 2010	CPT 2007
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based	Sep-05	Stereotactic Radiation Tx Delivery	7	September 2010	CPT 2007
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); linear accelerator based	Sep-05	Stereotactic Radiation Tx Delivery	7	September 2010	CPT 2007
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr-06	Stereotactic Body Radiation Therapy	B	September 2010	CPT 2007

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
77435	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	Apr-06	Stereotactic Body Radiation Therapy	B	September 2010	CPT 2007
88384	Array-based evaluation of multiple molecular probes; 11 through 50 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2009	CPT 2006
88385	Array-based evaluation of multiple molecular probes; 51 through 250 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2009	CPT 2006
88386	Array-based evaluation of multiple molecular probes; 251 through 500 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	September 2009	CPT 2006
96020	Neurofunctional testing selection and administration during non-invasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report	Feb-06	Functional MRI	15	September 2010	CPT 2007
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb-06	Whole Body Integumentary Photography	19	September 2010	CPT 2007
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements	Apr-06	Anticoagulant Management Services	I	September 2010	CPT 2007
99364	Anticoagulant management for a patient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of three INR measurements)	Apr-06	Anticoagulant Management Services	I	September 2010	CPT 2007
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb-07	Manual Microdisection	12	September 2011	CPT 2008
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb-07	Manual Microdisection	12	September 2011	CPT 2008
99441	Telephone Evaluation and Management, 5-10 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
99442	Telephone Evaluation and Management, 11-20 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008
99443	Telephone Evaluation and Management, 21-30 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	September 2011	CPT 2008
33257	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure); performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
33258	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
33259	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)	Apr-07	Add-on Maze Procedures	23	September 2011	CPT 2008
29828	Tenodesis of long tendon of biceps	Apr-07	Arthroscopic Biceps Tenodesis	17	September 2011	CPT 2008
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr-07	Cardiac MRI	F	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
75562	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
75564	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	September 2011	CPT 2008
20985	Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
20986	Computer assisted surgical navigational procedure for musculoskeletal procedures; with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound), (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
20987	Computer assisted surgical navigational procedure for musculoskeletal procedures; with image-guidance based on pre-operative images (eg, CT, MRI), (List separately in addition to code for primary procedure)	Apr-07	Computer Navigation	7	September 2011	CPT 2008
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr-07	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	September 2011	CPT 2008
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment of new subcutaneous infusion site(s)	Apr-07	Immune Globulin Subcutaneous Infusion	H	September 2011	CPT 2008
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr-07	Laparoscopic Paravaginal Defect Repair	C	September 2011	CPT 2008
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr-07	Nasolacrimal Duct Balloon Catheter Dilation	E	September 2011	CPT 2008
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr-07	Percutaneous Renal Tumor Cryotherapy	A	September 2011	CPT 2008
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	September 2011	CPT 2008
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr-07	PET Imaging	G	September 2011	CPT 2008
78813	Positron emission tomography (PET) imaging; whole body	Apr-07	PET Imaging	G	September 2011	CPT 2008
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	September 2011	CPT 2008
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr-07	PET Imaging	G	September 2011	CPT 2008

CPT Code	Descriptor	Meeting	Issue	Tab	Date to be Re-reviewed	CPT Year
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr-07	PET Imaging	G	September 2011	CPT 2008
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)	Apr-07	Valve Sparing Aortic Annulus Reconstruction	24	September 2011	CPT 2008
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data (List in addition to the code for the primary procedure)	Apr-07	Wireless Pressure Sensor Implantation	25	September 2011	CPT 2008
93982	Non-invasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Apr-07	Wireless Pressure Sensor Implantation	25	September 2011	CPT 2008
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58571	Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less; with removal of tubes and/or ovary(s)	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 gram	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
58573	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams; with removal of tubes and/or ovary(s)	Apr-07	Laparoscopic Total Hysterectomy	D	September 2011	CPT 2008
95966	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 5-10 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95967	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 11-20 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008
95968	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 21-30 minutes of medical discussion	Apr-07	Non Face-to-Face Qualified Healthcare Professional Services	U	September 2011	CPT 2008

Specialty and Acronym

Society	Acronym
AMA CPT Editorial Panel	AMA
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians & Investigators	AAPPI
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS

Society	Acronym
American College of Cardiology	ACC
American College of Chest Physicians	ACCP
American College of Emergency Physicians	ACEP
American College of Medical Genetics	ACMG
American College of Obstetricians and Gynecologists	ACOG
American College of Occupational and Environmental Medicine	ACOEM
American College of Physicians	ACP
American College of Preventive Medicine	ACPM
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Dietetic Association	ADiA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Institute of Ultrasound in Medicine	AIUM
American Medical Association	AMA
American Medical Directors Association	AMDA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Association	AOA-Ortho
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Roentgen Ray Society	ARRS

Society	Acronym
American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
American Society of Cytopathology	ASC
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Maxillofacial Surgeons	ASMS
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Ophthalmic Plastic and Reconstructive	ASOPRS
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP

Society	Acronym
Congress of Neurological Surgeons	CNS
Contact Lens Society of America	CLSA
Infectious Diseases Society of America	IDSA
International Spinal Injection Society	ISIS
International Spine Intervention Society	ISIS
Joint Council of Allergy Asthma and Immunology	JCAAI
Joint Council of Allergy, Asthma and Immunology	JCAAI
Medical Group Management Association	MGMA
MedPAC	MedPAC
National Association of Social Workers	NASW
North American Spine Society	NASS
Practice Expense Review Committee (PERC)	PERC
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine	SNM
Society of Thoracic Surgeons	STS
The Endocrine Society	TES
The Triological Society	TTS

CPT 2008 RUC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
01905	XXX	D	Feb07	20	Anesthesia for Radiologic Spine Procedures		Apr07	04	ASA				☑		☐
01935	XXX	N	Feb07	20	Anesthesia for Radiologic Spine Procedures	P1	Apr07	04	ASA	5.00	5.00		☑		☐
01936	XXX	N	Feb07	20	Anesthesia for Radiologic Spine Procedures	P2	Apr07	04	ASA	5.00	5.00		☑		☐
11008	ZZZ	R	Oct06	05	Mesh Implantation		Editorial			5.00	5.00	Yes	☑		☐
20555	000	N	Feb07	22	Soft Tissue Brachytherapy Implant Placement	Q1	Apr07	05	ASTRO	8.00	6.00		☑		☐
20660	000	R	Feb07	05	Application of Cranial Tongs	DD1	Apr07	19	AAOS, AANS/CNS	2.51	4.00		☑	Modifier -51 Exempt List Issue - Should not be Modifier - 51 exempt	☐
20690	090	R	Feb07	05	External Fixation	R1	Apr07	06	AAOS, AOFAS	8.65	8.65		☑	Five Year Review Issue, Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
20692	090	R	Feb07	05	External Fixation	R2	Apr07	06	AAOS, AOFAS	16.00	16.00		☑	Five Year Review Issue, Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
20930	ZZZ	R	Feb07	05	Modifier -51		Editorial			0.00	0.00	Yes	☑		☐
20931	ZZZ	R	Feb07	05	Modifier -51		Editorial			1.81	1.81	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
20936	ZZZ	R	Feb07	05	Modifier -51		Editorial			0.00	0.00	Yes	☑		☐
20937	ZZZ	R	Feb07	05	Modifier -51		Editorial			2.79	2.79	Yes	☑		☐
20938	ZZZ	R	Feb07	05	Modifier -51		Editorial			3.02	3.02	Yes	☑		☐
20985	ZZZ	N	Feb07	99	Computer Navigation	S1	Apr07	07	AAOS	2.50	2.50		☑		☑
20986	ZZZ	N	Feb07	99	Computer Navigation	S2	Apr07	07	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☑
20987	ZZZ	N	Feb07	99	Computer Navigation	S3	Apr07	07	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☑
21073	090	N	Jun06	09	Temporomandibular Joint Manipulation	A1	Oct06	07	AOMS	4.15	3.33		☑		☐
22102	090	R	Jun06	10	Posterior Distraction Device Insertion		Editorial			10.88	10.88	Yes	☑		☐
22206	090	N	Feb07	27	Three Column Osteotomy	U1	Apr07	09	NASS, AAOS, AANS/CNS	37.00	37.00		☑		☐
22207	090	N	Feb07	27	Three Column Osteotomy	U2	Apr07	09	NASS, AAOS, AANS/CNS	36.50	36.50		☑		☐
22208	ZZZ	N	Feb07	27	Three Column Osteotomy	U3	Apr07	09	NASS, AAOS, AANS/CNS	9.66	9.66		☑		☐
22840	ZZZ	R	Jun06	10	Posterior Distraction Device Insertion		Editorial			12.52	12.52	Yes	☑		☐
22840	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.52	12.52	Yes	☑		☐
22841	ZZZ	R	Feb07	05	Modifier -51		Editorial			0.00	0.00	Yes	☑		☐
22842	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.56	12.56	Yes	☑		☐
22843	ZZZ	R	Feb07	05	Modifier -51		Editorial			13.44	13.44	Yes	☑		☐
22844	ZZZ	R	Feb07	05	Modifier -51		Editorial			16.42	16.42	Yes	☑		☐
22845	ZZZ	R	Feb07	05	Modifier -51		Editorial			11.94	11.94	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
22846	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.40	12.40	Yes	☑		☐
22847	ZZZ	R	Feb07	05	Modifier -51		Editorial			13.78	13.78	Yes	☑		☐
22848	ZZZ	R	Feb07	05	Modifier -51		Editorial			5.99	5.99	Yes	☑		☐
22851	ZZZ	R	Feb07	05	Modifier -51		Editorial			6.70	6.70	Yes	☑		☐
22851	ZZZ	R	Jun06	10	Posterior Distraction Device Insertion		Editorial			6.70	6.70	Yes	☑		☐
23515	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F10	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	11.00	11.00		☑	Five Year Review Issue	☐
23585	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F3	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	16.25	16.25		☑	Five Year Review Issue	☐
23615	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F4	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	15.00	14.00		☑	Five Year Review Issue	☐
23616	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F5	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	21.00	21.00		☑	Five Year Review Issue	☐
23630	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F6	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	12.00	12.00		☑	Five Year Review Issue	☐
23670	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F7	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	14.00	14.00		☑	Five Year Review Issue	☐
23680	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F8	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	15.00	15.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
24350	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24351	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24352	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24354	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24356	090	D	Feb07	28	Epicondylitis Procedures		Apr07	10	AAOS, ASSH				☑		☐
24357	090	N	Feb07	28	Epicondylitis Procedures	V1	Apr07	10	AAOS, ASSH	5.32	5.32		☑		☐
24358	090	N	Feb07	28	Epicondylitis Procedures	V2	Apr07	10	AAOS, ASSH	6.54	6.54		☑		☐
24359	090	N	Feb07	28	Epicondylitis Procedures	V3	Apr07	10	AAOS, ASSH	8.86	8.86		☑		☐
24545	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F9	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	15.00	15.00		☑	Five Year Review Issue	☐
24546	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F11	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	22.00	17.01		☑	Five Year Review Issue	☐
24575	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F13	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	11.00	11.00		☑	Five Year Review Issue	☐
24579	090	R	Oct06	07	Internal or External Fixation - Shoulder/Elbow	F12	Feb07	04	AANA, AAOS, ASES, ASSH, OTA	13.00	13.00		☑	Five Year Review Issue	☐
24635	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F14	Feb07	05	AAOS, ASES, ASSH, OTA	10.00	10.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
24665	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F15	Feb07	05	AAOS, ASES, ASSH, OTA	8.22	8.22	Yes	☑	Five Year Review Issue - Referred to CPT	☐
24666	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F16	Feb07	05	AAOS, ASES, ASSH, OTA	9.74	9.74	Yes	☑	Five Year Review Issue - Referred to CPT	☐
24670	090	R	Feb07	29	Coronoid Fracture		Editorial			2.60	2.60	Yes	☑		☐
24675	090	R	Feb07	29	Coronoid Fracture		Editorial			4.79	4.79	Yes	☑		☐
24685	090	R	Feb07	29	Coronoid Fracture		Editorial			8.92	8.92	Yes	☑		☐
24685	090	R	Oct06	07	Internal or External Fixation - Elbow/Hnad	F17	Feb07	05	AAOS, ASES, ASSH, OTA	9.50	9.50		☑	Five Year Review Issue	☐
25515	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F18	Feb07	05	AAOS, ASES, ASSH, OTA	10.00	10.00		☑	Five Year Review Issue	☐
25525	090	R	Feb07	10	Internal or External Fixation		Editorial			12.69	12.69	Yes	☑	Five Year Review Issue	☐
25525	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F19	Feb07	05	AAOS, ASES, ASSH, OTA	12.00	12.00		☑	Five Year Review Issue	☐
25526	090	R	Feb07	10	Internal or External Fixation		Editorial			13.43	13.43	Yes	☑	Five Year Review Issue	☐
25526	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F20	Feb07	05	AAOS, ASES, ASSH, OTA	15.00	15.00		☑	Five Year Review Issue	☐
25545	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F21	Feb07	05	AAOS, ASES, ASSH, OTA	9.00	9.00		☑	Five Year Review Issue	☐
25574	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F22	Feb07	05	AAOS, ASES, ASSH, OTA	10.00	10.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
25575	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F23	Feb07	05	AAOS, ASES, ASSH, OTA	14.00	14.00		☑	Five Year Review Issue	☐
25620	090	D	Oct06	07	Internal or External Fixation - Elbow/Hand		Feb07	05	AAOS, ASES, ASSH, OTA				☑	Five Year Review Issue	☐
25628	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F24	Feb07	05	AAOS, ASES, ASSH, OTA	11.00	11.00		☑	Five Year Review Issue	☐
26615	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F25	Feb07	05	AAOS, ASES, ASSH, OTA	8.00	8.00		☑	Five Year Review Issue	☐
26650	090	R	Feb07	10	Internal or External Fixation		Editorial			5.80	5.80	Yes	☑	Five Year Review Issue	☐
26650	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F26	Feb07	05	AAOS, ASES, ASSH, OTA	6.00	6.00		☑	Five Year Review Issue	☐
26665	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F27	Feb07	05	AAOS, ASES, ASSH, OTA	9.00	9.00		☑	Five Year Review Issue	☐
26685	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F28	Feb07	05	AAOS, ASES, ASSH, OTA	8.00	8.00		☑	Five Year Review Issue	☐
26715	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F29	Feb07	05	AAOS, ASES, ASSH, OTA	7.95	7.95		☑	Five Year Review Issue	☐
26735	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F30	Feb07	05	AAOS, ASES, ASSH, OTA	8.40	8.40		☑	Five Year Review Issue	☐
26746	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F31	Feb07	05	AAOS, ASES, ASSH, OTA	11.10	11.10		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
26765	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F32	Feb07	05	AAOS, ASES, ASSH, OTA	6.60	6.60		☑	Five Year Review Issue	☐
26785	090	R	Oct06	07	Internal or External Fixation - Elbow/Hand	F33	Feb07	05	AAOS, ASES, ASSH, OTA	7.45	7.45		☑	Five Year Review Issue	☐
27248	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F34	Apr07	12	AAOS, AAHKS, OTA	12.83	12.83		☑	Five Year Review Issue	☐
27267	090	N	Feb07	33	Femoral Head Fracture Treatment	W1	Apr07	11	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☐
27268	090	N	Feb07	33	Femoral Head Fracture Treatment	W2	Apr07	11	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☐
27269	090	N	Feb07	33	Femoral Head Fracture Treatment	W3	Apr07	11	AAOS	Carrier Priced	Carrier Priced		☑	Interim Value - September 07 RUC	☐
27416	090	N	Feb07	34	Open Knee Osteochondral Autograft	X1	Apr07	13	AAOS	14.00	14.00		☑		☐
27511	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F35	Apr07	12	AAOS, AAHKS, OTA	18.05	18.05		☑	Five Year Review Issue	☐
27513	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F36	Apr07	12	AAOS, AAHKS, OTA	23.04	23.04		☑	Five Year Review Issue	☐
27514	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F37	Apr07	12	AAOS, AAHKS, OTA	17.43	17.43		☑	Five Year Review Issue	☐
27519	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F38	Apr07	12	AAOS, AAHKS, OTA	15.80	15.80	Yes	☑	Five Year Review Issue	☐
27535	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F39	Apr07	12	AAOS, AAHKS, OTA	16.00	16.00		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
27540	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F40	Apr07	12	AAOS, AAHKS, OTA	13.45	13.45	Yes	☑	Five Year Review Issue	☐
27556	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F41	Apr07	12	AAOS, AAHKS, OTA	15.50	15.50		☑	Five Year Review Issue	☐
27557	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F42	Apr07	12	AAOS, AAHKS, OTA	19.00	19.00		☑	Five Year Review Issue	☐
27558	090	R	Oct06	07	Internal or External Fixation - Hip and Knee	F43	Apr07	12	AAOS, AAHKS, OTA	22.00	22.00		☑	Five Year Review Issue	☐
27726	090	N	Feb07	35	Fibula Malunion	Z1	Apr07	15	AAOS, AOFAS	14.20	14.20		☑		☐
27766	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F44	Feb07	06	AAOS, AOFAS, APMA, OTA	8.50	8.50		☑	Five Year Review Issue	☐
27767	090	N	Feb07	36	Posterior Malleolar Fracture Treatment	Y1	Apr07	14	AAOS, AOFAS	2.50	2.50		☑		☐
27768	090	N	Feb07	36	Posterior Malleolar Fracture Treatment	Y2	Apr07	14	AAOS, AOFAS	5.00	5.00		☑		☐
27769	090	N	Feb07	36	Posterior Malleolar Fracture Treatment	Y3	Apr07	14	AAOS, AOFAS	10.00	10.00		☑		☐
27784	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F45	Feb07	06	AAOS, AOFAS, APMA, OTA	10.45	10.45		☑	Five Year Review Issue	☐
27792	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F46	Feb07	06	AAOS, AOFAS, APMA, OTA	10.50	10.50		☑	Five Year Review Issue	☐
27808	090	R	Feb07	37	Bimalleolar Ankle Fracture		Editorial			2.91	2.91	Yes	☑		☐
27810	090	R	Feb07	37	Bimalleolar Ankle Fracture		Editorial			5.20	5.20	Yes	☑		☐
27814	090	R	Feb07	37	Bimalleolar Ankle Fracture		Editorial			11.10	11.10	Yes	☑		☐
27814	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F47	Feb07	06	AAOS, AOFAS, APMA, OTA	14.20	11.50		☑	Five Year Review Issue	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
27822	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F48	Feb07	06	AAOS, AOFAS, APMA, OTA	14.75	12.12	Yes	☑	Five Year Review Issue	☐
27823	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F49	Feb07	06	AAOS, AOFAS, APMA, OTA	15.00	14.26	Yes	☑	Five Year Review Issue	☐
27826	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F50	Feb07	06	AAOS, AOFAS, APMA, OTA	14.00	12.00		☑	Five Year Review Issue	☐
27827	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F51	Feb07	06	AAOS, AOFAS, APMA, OTA	20.00	16.00		☑	Five Year Review Issue	☐
27828	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F52	Feb07	06	AAOS, AOFAS, APMA, OTA	24.00	20.00		☑	Five Year Review Issue	☐
27829	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F53	Feb07	06	AAOS, AOFAS, APMA, OTA	9.50	9.50		☑	Five Year Review Issue	☐
27832	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F54	Feb07	06	AAOS, AOFAS, APMA, OTA	11.00	11.00		☑	Five Year Review Issue	☐
28415	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F55	Feb07	06	AAOS, AOFAS, APMA, OTA	20.06	17.54	Yes	☑	Five Year Review Issue	☐
28420	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F56	Feb07	06	AAOS, AOFAS, APMA, OTA	23.50	19.00		☑	Five Year Review Issue	☐
28445	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F57	Feb07	06	AAOS, AOFAS, APMA, OTA	21.50	17.07	Yes	☑	Five Year Review Issue	☐
28446	090	N	Feb07	38	Open Osteochondral Talus Graft	AA1	Apr07	16	AAOS, APMA, AOFAS	17.50	17.50		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
28465	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F58	Feb07	06	AAOS, AOFAS, APMA, OTA	10.50	9.50		☑	Five Year Review Issue	☐
28485	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F59	Feb07	06	AAOS, AOFAS, APMA, OTA	8.00	8.00		☑	Five Year Review Issue	☐
28505	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F60	Feb07	06	AAOS, AOFAS, APMA, OTA	8.30	8.00		☑	Five Year Review Issue	☐
28525	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F61	Feb07	06	AAOS, AOFAS, APMA, OTA	6.00	6.00		☑	Five Year Review Issue	☐
28555	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F62	Feb07	06	AAOS, AOFAS, APMA, OTA	10.43	10.43		☑	Five Year Review Issue	☐
28585	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F63	Feb07	06	AAOS, AOFAS, APMA, OTA	12.00	12.00		☑	Five Year Review Issue	☐
28615	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F64	Feb07	06	AAOS, AOFAS, APMA, OTA	11.50	11.50		☑	Five Year Review Issue	☐
28645	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F65	Feb07	06	AAOS, AOFAS, APMA, OTA	8.00	8.00		☑	Five Year Review Issue	☐
28675	090	R	Oct06	07	Internal or External Fixation - Foot and Ankle	F66	Feb07	06	AAOS, AOFAS, APMA, OTA	6.00	6.00		☑	Five Year Review Issue	☐
29828	090	N	Feb07	39	Arthroscopic Biceps Tendesis	BB1	Apr07	17	AAOS	13.00	13.00		☑		☑
29855	090	R	Feb07	10	Internal or External Fixation		Editorial			10.60	10.60	Yes	☑	Five Year Review Issue	☐
29856	090	R	Feb07	10	Internal or External Fixation		Editorial			14.12	14.12	Yes	☑	Five Year Review Issue	☐

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29904	090	N	Feb07	30	Subtalar Arthroscopy	CC1	Apr07	18	AAOS, APMA, AOFAS	8.50	8.50		☑		☐
29905	090	N	Feb07	30	Subtalar Arthroscopy	CC2	Apr07	18	AAOS, APMA, AOFAS	9.00	9.00		☑		☐
29906	090	N	Feb07	30	Subtalar Arthroscopy	CC3	Apr07	18	AAOS, APMA, AOFAS	9.47	9.47		☑		☐
29907	090	N	Feb07	30	Subtalar Arthroscopy	CC4	Apr07	18	AAOS, APMA, AOFAS	12.00	12.00		☑		☐
31500	000	R	Feb07	05	Insert Emergency Airway	DD2	Apr07	20	ASA, ACEP	2.55	2.33	Yes	☑	Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
33257	ZZZ	N	Feb07	41	Add-On Maze Procedures	EE1	Apr07	23	STS	9.63	9.63		☑		☑
33258	ZZZ	N	Feb07	41	Add-On Maze Procedures	EE2	Apr07	23	STS	11.00	11.00		☑		☑
33259	ZZZ	N	Feb07	41	Add-on Maze Procedures	EE3	Apr07	23	STS	14.14	14.14		☑		☑
33517	ZZZ	R	Feb07	05	Modifier -51		Editorial			3.61	3.61	Yes	☑		☐
33518	ZZZ	R	Feb07	05	Modifier -51		Editorial			7.93	7.93	Yes	☑		☐
33519	ZZZ	R	Feb07	05	Modifier -51		Editorial			10.49	10.49	Yes	☑		☐
33521	ZZZ	R	Feb07	05	Modifier -51		Editorial			12.59	12.59	Yes	☑		☐
33522	ZZZ	R	Feb07	05	Modifier -51		Editorial			14.14	14.14	Yes	☑		☐
33523	ZZZ	R	Feb07	05	Modifier -51		Editorial			16.08	16.08	Yes	☑		☐
33861	090	R	Feb07	42	Valve Sparing Aortic Annulus Reconstruction	FF1	Apr07	24	STS	43.94	43.94	Yes	☑		☐
33863	090	R	Feb07	42	Valve Sparing Aortic Annulus Reconstruction	FF2	Apr07	24	STS	58.71	58.71	Yes	☑		☐
33864	090	N	Feb07	42	Valve Sparing Aortic Annulus Reconstruction	FF3	Apr07	24	STS	60.00	60.00		☑		☑

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34806	ZZZ	N	Feb07	96	Wireless Pressue Sensor Implantation and Study	GG1	Apr07	25	SVS, SIR, ACR	2.06	2.06		☑		☑
35523	090	N	Feb07	43	Brachial-Ulnar Bypass Graft	HH1	Apr07	26	SVS	24.00	24.00		☑		☐
35600	ZZZ	R	Feb07	05	Modifier -51		Editorial			30.15	30.15	Yes	☑		☐
36540	XXX	D	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO				☑		☐
36550	XXX	D	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO				☑		☐
36591	XXX	N	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO	0.00	0.00		☑	Practice Expense Inputs Only, Renumbered Code from 36540	☐
36592	XXX	N	Jun06	11	Non-implantable Venous Access Device Blood Draws	B1	Oct06	08	ASCO	0.00	0.00		☑	Practice Expense Inputs Only	☐
36593	XXX	N	Jun06	11	Non-implantable Venous Access Device Blood Draws		Oct06	08	ASCO	0.00	0.00		☑	Practice Expense Inputs Only, Renumbered Code from 36550	☐
36620	000	R	Feb07	05	Arterial Catheterization	DD3	Apr07	21	ASA	1.50	1.15	Yes	☑	Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
36838	090	R	Feb07	43	Brachial-Ulnar Bypass Graft		Apr07	26	SVS	21.59	21.59	Yes	☑		☐
41019	000	N	Feb07	46	Head and Neck Interstitial Brachytherapy Needle or Catheter Placement	II1	Apr07	27	ASTRO	11.00	8.84		☑		☐
43246	000	R	Feb07	50	G-, J-, G-J, C-Tube Procedures		Apr07	29		4.32	4.32	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43750	010	D	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK10	Apr07	29	SIR, ACR, ACS				☑		☐
43760	000	R	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK11	Apr07	29	SIR, ACR, AGA, ASGE	1.10	0.90		☑	Interim Value - September 07 RUC	☐
43770	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			17.85	17.85	Yes	☑		☐
43771	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			20.64	20.64	Yes	☑		☐
43772	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			15.62	15.62	Yes	☑		☐
43773	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			20.64	20.61	Yes	☑		☐
43774	090	R	Feb07	47	Laparoscopic Gastric Restrictive Procedure		Editorial			15.66	15.66	Yes	☑		☐
47719	090	D	Feb07	48	Choledochal Cyst Anastomosis		Deleted						☑		☐
49200	090	D	Feb07	49	Peritoneal Tumor Ablation		Apr07	28	ACS				☑		☐
49201	090	D	Feb07	49	Peritoneal Tumor Ablation		Apr07	28	ACS				☑		☐
49203	090	N	Feb07	49	Peritoneal Tumor Ablation	JJ1	Apr07	28	ACS, ACOG	19.69	20.00		☑		☐
49204	090	N	Feb07	49	Peritoneal Tumor Ablation	JJ2	Apr07	28	ACS, ACOG	26.00	26.00		☑		☐
49205	090	N	Feb07	49	Peritoneal Tumor Ablation	JJ3	Apr07	28	ACS	30.00	30.00		☑		☐
49441	010	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK1	Apr07	29	SIR, ACR	4.60	3.32		☑	Interim Value - September 07 RUC	☐
49441	010	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK2	Apr07	29	SIR, ACR	7.00	5.72		☑	Interim Value - September 07 RUC	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
49442	010	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK3	Apr07	29	SIR, ACR	6.58	3.87		☑	Interim Value - September 07 RUC	☐
49446	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK4	Apr07	29	SIR, ACR	3.50	2.94		☑	Interim Value - September 07 RUC	☐
49450	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK5	Apr07	29	SIR, ACR	1.50	1.14		☑	Interim Value - September 07 RUC	☐
49451	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK6	Apr07	29	SIR, ACR	2.20	1.82		☑	Interim Value - September 07 RUC	☐
49452	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK7	Apr07	29	SIR, ACR	3.30	2.81		☑	Interim Value - September 07 RUC	☐
49460	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK8	Apr07	29	SIR, ACR	2.00	1.51		☑	Interim Value - September 07 RUC	☐
49465	000	N	Feb07	50	G-, J-, G-J, C-Tube Procedures	KK9	Apr07	29	SIR, ACR	0.76	0.62		☑	Interim Value - September 07 RUC	☐
49568	ZZZ	R	Oct06	05	Mesh Implantation		Editorial			5.00	5.00	Yes	☑		☐
50385	000	N	Oct06	13	Transuretheral Ureteral Stent Tube Exchange and Removal	G1	Feb07	07	ACR, SIR	4.44	4.44		☑		☐
50386	000	N	Oct06	13	Transuretheral Ureteral Stent Tube Exchange and Removal	G2	Feb07	07	ACR, SIR	3.30	3.30		☑		☐
50593	010	N	Feb07	97	Percutaneous Renal Tumor Cryotherapy	MM1	Apr07	A	AUA, SIR, ACR	13.00	9.08		☑		☑
51797	ZZZ	R	Oct06	14	Intra-Abdominal Voiding Pressure	H1	Apr07	30	AUA	0.80	0.80		☑	Global period change	☐

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52510	090	D	Feb07	51	Transuretheral Balloon Dilation of the Prostatic Urethra		Deleted						☑		☐
52601	090	R	Feb07	52	Prostate Laser Enucleation		Apr07	B	AUA	15.13	15.13	Yes	☑		☐
52647	090	R	Feb07	52	Prostate Laser Enucleation	NN1	Apr07	B	AUA	11.15	11.15	Yes	☑		☐
52648	090	R	Feb07	52	Prostate Laser Enucleation	NN2	Apr07	B	AUA	12.00	12.00	Yes	☑		☐
52649	090	N	Feb07	52	Prostate Laser Enucleation	NN3	Apr07	B	AUA	17.16	17.16		☑		☐
55920	000	N	Feb07	56	Pelvic Interstitial Brachytherapy Needle or Catheter Placement	LL1	Apr07	31	ASTRO	10.50	8.31		☑		☐
57284	090	R	Feb07	31	Laparaoscopic Paravaginal Defect Repair	OO1	Apr07	C	ACOG	14.25	14.25		☑		☐
57285	090	N	Feb07	31	Laparaoscopic Paravaginal Defect Repair	OO2	Apr07	C	ACOG	11.52	11.52		☑		☐
57423	090	N	Feb07	31	Laparaoscopic Paravaginal Defect Repair	OO3	Apr07	C	ACOG	16.00	16.00		☑		☑
57500	000	R	Feb07	53	Biopsy of Cervix		Editorial			1.20	1.20	Yes	☑		☐
58550	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP5	Apr07	D	ACOG	14.97	14.97	Yes	☑		☐
58552	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP6	Apr07	D	ACOG	16.78	16.78	Yes	☑		☐
58553	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP7	Apr07	D	ACOG	19.96	19.96	Yes	☑		☐
58554	090	R	Feb07	55	Laparoscopic Total Hysterectomy	PP8	Apr07	D	ACOG	22.98	22.98	Yes	☑		☐
58570	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP1	Apr07	D	ACOG	15.75	15.75		☑		☑
58571	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP2	Apr07	D	ACOG	17.56	17.56		☑		☑
58572	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP3	Apr07	D	ACOG	19.96	19.96		☑		☑

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58573	090	N	Feb07	55	Laparoscopic Total Hysterectomy	PP4	Apr07	D	ACOG	22.98	22.98		☑		☑
67038	090	D	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping		Feb07	09	AAO				☑	Five Year Review Issue	☐
67041	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I1	Feb07	09	AAO	19.00	19.00		☑	Five Year Review Issue	☐
67042	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I2	Feb07	09	AAO	22.13	22.13		☑	Five Year Review Issue	☐
67043	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I3	Feb07	09	AAO	22.94	22.94		☑	Five Year Review Issue	☐
67108	090	R	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I4	Feb07	09	AAO	22.49	22.49	Yes	☑	Five Year Review Issue	☐
67113	090	N	Oct06	19	Vitrectomy with Epiretinal Membrane Stripping	I5	Feb07	09	AAO	25.00	25.00		☑	Five Year Review Issue	☐
67227	090	R	Oct06	20	Retinopathy Treatment		Feb07	10	AAO	7.38	7.38	Yes	☑	Five Year Review Issue	☐
67228	090	R	Oct06	20	Retinopathy Treatment	J1	Feb07	10	AAO	13.67	13.67	Yes	☑	Five Year Review Issue	☐
67229	090	N	Oct06	20	Retinopathy Treatment	J2	Feb07	10	AAO	16.00	16.00		☑	Five Year Review Issue	☐
68816	010	N	Feb07	57	Nasolacrimal Duct Balloon Catheter Dilation	QQ1	Apr07	E	AAO	3.00	3.00		☑		☑
70496	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.75	1.75	Yes	☑		☐
70498	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.75	1.75	Yes	☑		☐
71275	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.92	1.92	Yes	☑		☐
72191	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.81	1.81	Yes	☑		☐

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73206	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.81	1.81	Yes	☑		☐
73706	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.90	1.90	Yes	☑		☐
74175	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			1.90	1.90	Yes	☑		☐
74350	XXX	D	Feb07	50	G-, J-, G-J, C-Tube Procedures		Apr07	29					☑		☐
75552	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75553	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75554	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75555	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75556	XXX	D	Feb07	13	Cardiac MRI		Apr07	F	ACR, ACC				☑	Five Year Review Issue	☐
75557	XXX	N	Feb07	13	Cardiac MRI	RR1	Apr07	F	ACR, ACC	2.35	2.35		☑	Five Year Review Issue	☑
75558	XXX	N	Feb07	13	Cardiac MRI	RR2	Apr07	F	ACR, ACC	2.60	2.60		☑	Five Year Review Issue	☑
75559	XXX	N	Feb07	13	Cardiac MRI	RR3	Apr07	F	ACR, ACC	2.95	2.95		☑	Five Year Review Issue	☑
75560	XXX	N	Feb07	13	Cardiac MRI	RR4	Apr07	F	ACR, ACC	3.00	3.00		☑	Five Year Review Issue	☑
75561	XXX	N	Feb07	13	Cardiac MRI	RR5	Apr07	F	ACR, ACC	2.60	2.60		☑	Five Year Review Issue	☑
75562	XXX	N	Feb07	13	Cardiac MRI	RR6	Apr07	F	ACR, ACC	2.86	2.86		☑	Five Year Review Issue	☑
75563	XXX	N	Feb07	13	Cardiac MRI	RR7	Apr07	F	ACR, ACC	3.00	3.00		☑	Five Year Review Issue	☑
75564	XXX	N	Feb07	13	Cardiac MRI	RR8	Apr07	F	ACR, ACC	3.35	3.35		☑	Five Year Review Issue	☑
75635	XXX	R	Feb07	59	Computed Tomographic Angiography		Editorial			2.40	2.40	Yes	☑		☐

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75984	XXX	R	Feb07	50	G-, J-, G-J, C-Tube Procedures		Apr07	29		0.72	0.72	Yes	☑		☐
76376	XXX	R	Jun06	40	Computer Aided Detection and Algorithm Analysis of Breast MRI		Editorial			0.20	0.20	Yes	☑		☐
76377	XXX	R	Jun06	40	Computer Aided Detection and Algorithm Analysis of Breast MRI		Editorial			0.79	0.79	Yes	☑		☐
77371	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			0.00	0.00	Yes	☑		☐
77372	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			0.00	0.00	Yes	☑		☐
77432	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			7.92	7.92	Yes	☑		☐
77435	XXX	R	Jun06	16	Cranial Lesion Stereotactic Radiation Treatment Management		Editorial			13.00	13.00	Yes	☑		☐
78600	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K1	Editorial		SNM, ACR	0.44	0.44	Yes	☑	PE Recommendations Only	☐
78601	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K2	Editorial		SNM, ACR	0.51	0.51	Yes	☑	PE Recommendations Only	☐
78605	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K3	Editorial		SNM, ACR	0.53	0.53	Yes	☑	PE Recommendations Only	☐
78606	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K4	Editorial		SNM, ACR	0.64	0.64	Yes	☑	PE Recommendations Only	☐

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78607	XXX	R	Oct06	23	Brain and Cerebrospinal Fluid Imaging	K5	Editorial		SNM, ACR	1.23	1.23	Yes	☑	PE Recommendations Only	☐
78615	XXX	D	Oct06	23	Brain and Cerebrospinal Fluid Imaging		Deleted		SNM, ACR				☑		☐
78811	XXX	R	Feb07	58	PET Imaging	YY1	Apr07	G	SNM, ACR	1.54	1.54	Yes	☑		☑
78812	XXX	R	Feb07	58	PET Imaging	YY2	Apr07	G	SNM, ACR	1.93	1.93	Yes	☑		☑
78813	XXX	R	Feb07	58	PET Imaging	YY3	Apr07	G	SNM, ACR	2.00	2.00	Yes	☑		☑
78814	XXX	R	Feb07	58	PET Imaging	YY4	Apr07	G	SNM, ACR	2.20	2.20	Yes	☑		☑
78815	XXX	R	Feb07	58	PET Imaging	YY5	Apr07	G	SNM, ACR	2.44	2.44	Yes	☑		☑
78816	XXX	R	Feb07	58	PET Imaging	YY6	Apr07	G	SNM, ACR	2.50	2.50	Yes	☑		☑
80047	XXX	N	Feb07	102	Basic Metabolic Panel		CLFS						☐		☐
80048	XXX	R	Feb07	102	Basic Metabolic Panel		CLFS						☐		☐
82272	XXX	R	Oct06	29	Diagnositc Occult Blood Test		CLFS						☐		☐
82610	XXX	N	Feb07	62	Cystatin C		CLFS						☐		☐
83021	XXX	R	Feb07	63	Ion Exchange HPLC Glycosylated Hemoglobin Test		CLFS						☐		☐
83036	XXX	R	Feb07	63	Ion Exchange HPLC Glycosylated Hemoglobin Test		CLFS						☐		☐
83656	XXX	N	Feb07	69	Unlisted Antigen		CLFS						☐		☐
83898	XXX	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83900	XXX	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83901	ZZZ	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83908	XXX	R	Jun06	19	DNA Acid Signal Amplification		CLFS						☐		☐
83993	XXX	N	Feb07	67	Calprotectin		CLFS						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
84704	XXX	N	Feb07	65	Human Free Chorionic Gonadotropin		CLFS						☐		☐
86486	XXX	N	Feb07	69	Unlisted Antigen		CLFS						☐		☐
86586	XXX	D	Feb07	69	Unlisted Antigen		Deleted						☐		☐
86885	XXX	R	Oct06	51	Antibody Screening - Indirect Antiglobulin Test Tube		CLFS						☐		☐
86886	XXX	R	Oct06	51	Antibody Screening - Indirect Antiglobulin Test Tube		CLFS						☐		☐
87500	XXX	N	Feb07	72	Nucleic Acid Vancomycin Resistant Enterococcus Species Detection		CLFS						☐		☐
87809	XXX	N	Feb07	71	Adenoviral Conjunctivitis Detection		CLFS						☐		☐
88380	XXX	R	Oct06	26	Manual Microdisection	L2	Feb07	12	CAP	1.56	1.56		☑		☑
88381	XXX	N	Oct06	26	Manual Microdisection	L1	Feb07	12	CAP	1.18	1.18		☑		☑
89320	XXX	R	Oct06	28	Complete Semen Analysis with Morphology Assessment		CLFS						☐		☐
89321	XXX	R	Oct06	28	Complete Semen Analysis with Morphology Assessment		CLFS						☐		☐
89322	XXX	N	Oct06	28	Complete Semen Analysis with Morphology Assessment		CLFS						☐		☐
89331	XXX	N	Oct06	27	Retrograde Ejaculation Analysis		CLFS						☐		☐
90284	XXX	N	Feb07	80	Immune Globulin Subcutaneous Infusion		CLFS						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
90661	XXX	N	Feb07	76	Cultured Derived Influenza Vaccine		CLFS						☐		☐
90662	XXX	N	Feb07	78	High Dose Intramuscular Influenza Vaccine		CLFS						☐		☐
90663	XXX	N	Feb07	78	Pandemic Influenza Virus Vaccine		CLFS						☐		☐
90761	ZZZ	R	Feb07	81	Facility Therapeutic Infusions		Editorial			0.09	0.09	Yes	☑		☐
90766	ZZZ	R	Oct06	09	Drug Administration Procedures Clarification		Editorial			0.18	0.18	Yes	☑		☐
90769	XXX	N	Feb07	80	Immune Globulin Subcutaneous Infusion	SS1	Apr07	H	JCAAI	0.25	0.21		☑		☑
90770	ZZZ	N	Feb07	80	Immune Globulin Subcutaneous Infusion	SS2	Apr07	H	JCAAI	0.19	0.18		☑		☑
90771	ZZZ	N	Feb07	80	Immune Globulin Subcutaneous Infusion	SS3	Apr07	H	JCAAI	0.21	0.00		☑	Practice Expense Inputs Only	☑
90776	ZZZ	N	Feb07	81	Facility Therapeutic Infusions		No MFS						☐	Not Payable on Physician Fee Schedule	☐
93503	000	R	Feb07	05	Insertion and Placement of Heart Catheter	DD4	Apr07	22	ASA	2.91	2.91	Yes	☑	Modifier -51 Exempt List Issue - Should be Modifer -51 Exempt	☐
93539	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			0.40	0.40	Yes	☑		☐
93545	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			0.40	0.40	Yes	☑		☐
93555	XXX	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93556	XXX	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐
93561	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐
93562	000	R	Jun06	28	Cardiac Catheterization Injection Procedures		Editorial			Carrier Priced for Professional Component	Carrier Priced for Professional Component	Yes	☑		☐
93982	XXX	N	Feb07	96	Wireless Pressue Sensor Implantation and Study	GG2	Apr07	25	SVS, SIR, ACR	0.30	0.30		☑		☑
95004	XXX	R	Feb06	93	Allergy Test Interpretation		Feb07	21	JCAAI, AAOA	0.01	0.01		☑	Five Year Review Issue	☐
95024	XXX	R	Feb06	93	Allergy Test Interpretation		Feb07	21	JCAAI, AAOA	0.01	0.01		☑	Five Year Review Issue	☐
95027	XXX	R	Feb06	93	Allergy Test Interpretation		Feb07	21	JCAAI, AAOA	0.01	0.01		☑	Five Year Review Issue	☐
95980	XXX	N	Oct06	38	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	M1	Apr07	I	AGA, ASGE, ACG, AMS	0.80	0.80	Yes	☑		☑
95981	XXX	N	Oct06	38	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	M2	Apr07	I	AGA, ASGE, ACG, AMS	0.30	0.30	Yes	☑		☑
95982	XXX	N	Oct06	38	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	M3	Apr07	I	AGA, ASGE, ACG, AMS	0.65	0.65	Yes	☑		☑
96101	XXX	R	Feb07	101	Psychological Neuropsychological Testing Codes		Editorial			1.86	1.86	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
96118	XXX	R	Feb07	101	Psychological Neuropsychological Testing Codes		Editorial			1.86	1.86	Yes	☑		☐
96415	ZZZ	R	Oct06	09	Drug Administration Procedures Clarification		Editorial			0.19	0.19	Yes	☑		☐
96423	ZZZ	R	Oct06	09	Drug Administration Procedures Clarification		Editorial			0.17	0.17	Yes	☑		☐
96523	XXX	R	Jun06	27	Implanted Venous Access Device Irrigation		Editorial			0.04	0.04	Yes	☑		☐
99174	XXX	N	Feb07	92	Ocular Photoscreening	UU1	Apr07	J					☑	No RUC Recommendation	☐
99361	XXX	D	Jun06	06	Team Conference - RUC		Apr07	K	AGS				☑		☐
99362	XXX	D	Jun06	06	Team Conference - RUC		Apr07	K	AGS				☑		☐
99367	XXX	N	Jun06	06	Team Conference - RUC	C3	Apr07	K	AGS	1.10	1.10		☑		☐
99371	XXX	D	Oct06	06	Non-Face to Face Physician - RUC		Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				☑		☐
99372	XXX	D	Oct06	06	Non-Face to Face Physician - RUC		Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				☑		☐
99373	XXX	D	Oct06	06	Non-Face to Face Physician - RUC		Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				☑		☐
99406	XXX	N	Feb07	19	Smoking Cessation	VV1	Apr07	L	ACCP/ATS, ACP	0.24	0.24		☑		☐
99407	XXX	N	Feb07	19	Smoking Cessation	VV2	Apr07	L	ACCP/ATS, ACP	0.50	0.50		☑		☐
99408	XXX	N	Feb07	14	Alcohol, Drug Screening and Brief Intervention	WW1	Apr07	M	APA, AAFP, ACP	0.65	0.65		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99409	XXX	N	Feb07	14	Alcohol, Drug Screening and Brief Intervention	WW2	Apr07	M	APA, AAFP, ACP	1.30	1.30		☑		☐
99441	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O1	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	0.35	0.25		☑		☑
99442	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O2	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	0.60	0.50		☑		☑
99443	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O3	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	0.92	0.75		☑		☑
99444	XXX	N	Oct06	06	Non-Face to Face Physician - RUC	O4	Feb07	15	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR	Carrier Priced	Carrier Priced		☑		☐
99477	XXX	N	Oct06	30	Initial Day Hospital Neonate Care	N1	Feb07	14	AAP	7.00	7.00		☑		☐
99605	XXX	N	Feb07	94	Medication Therapy Management Services		No MFS						☐	No Medicare Physician Payment Schedule Benefit for Pharmacist Services	☐
99606	XXX	N	Feb07	94	Medication Therapy Management Services		No MFS						☐	No Medicare Physician Payment Schedule Benefit for Pharmacist Services	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99607	ZZZ	N	Feb07	94	Medication Therapy Management Services		No MFS						☐	No Medicare Physician Payment Schedule Benefit for Pharmacist Services	☐

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Open Osteochondral Talus Graft

The CPT Editorial Panel created one new Category I CPT code in February 2007 to describe an open osteochondral autograft not presently included in CPT. Prior to this new code, the service was accounted for by using more general coding to describe only the incision of the tibia and/or fibula.

The RUC reviewed the specialty societies' survey results for CPT code 28446, *Open osteochondral autograft, talus (includes obtaining graft[s]).* The specialties commented that the service is a highly complex surgery representing only the most complex and difficult patient population. The key reference service, 29892, *Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)* (work RVU = 10.07) which was selected by 29% of respondents, differs significantly from the procedure surveyed. Given the low service performance rate (median = 4), the specialties convened an expert consensus panel consisting of general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, and sports medicine specialists to review the survey data compared with the reference code and other orthopaedic and podiatric services and assess more closely the complexity of the procedure. The consensus panel agreed that the surveyed median intra-service time (90 minutes) and work RVU (16.00) were both too low. Rather, the panel believed that the 75th percentile intra-service time (120 minutes) and work RVU (17.50) were an appropriate estimation of time and physician work. The specialty societies commented that the procedure involves three distinct procedures, malleolar osteotomy and repair, osteochondral transplantation of the talus, and harvesting of the osteochondral grafts from the knee. The physician work for similar codes describing each of these procedures far exceeds the 75th percentile of the survey median; code 29874, *Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)* (work RVW = 7.10); 29866, *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)* (work RVW = 14.48); and 27705, *Osteotomy; tibia* (work RVW= 10.74). If these three procedures are billed separately with appropriate modifier reductions, the total work RVW totals 23.40 [14.48 + (7.10 x 50%) + (10.74 x 50%)]. The RUC agreed with the consensus panel and concurred that the 75th percentile intra-service time and work RVU appropriately accounted for and appropriately valued the physician work involved. The reference service, which is not an analogous service includes only 90 minutes of intra-service time, opposed to the 120 minutes recommended by the specialties and only 10 minutes of pre-service time versus 65 minutes in the surveyed code. The

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resulting difference in total time is 339 minutes versus 261 minutes within the reference service. The intensity and complexity measures also reveal that the survey respondents believed that 284XX was much more intense that the reference service.

The RUC did note that the single 99231 hospital visit included duplicative work accounted for in the full 99238 discharge management visit within the code's global period. The RUC removed this visit, leaving one 99238, two 99212, and three 99213 visits within the global period. The RUC recommends physician pre-service time of 65 minutes, intra-service time of 120 minutes and immediate post-service time of 15 minutes for 28446

The RUC recommends the specialty society survey 75th percentile work RVU of 17.50 for 28446.

Practice Expense

The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●28446	AA1	Open osteochondral autograft, talus (includes obtaining graft[s]) (Do not report 28446 in conjunction with 27705, 27707) (For arthroscopic osteochondral talus graft, use 29892) (For open osteochondral allograft or repairs with industrial grafts use 27599)	090	17.50
29892		Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	090	10.07 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28446 Tracking Number AA1 Specialty Society Recommended RVU: **17.50**
Global Period: 090 RUC Recommended RVU: **17.50**

CPT Descriptor: Open osteochondral autograft, talus (includes obtaining graft[s])

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient has sustained a symptomatic osteochondritis dissecans (OCD) lesion of the talus and has failed the usual arthroscopic or open debridement and drilling.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation rapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, an ankle arthrotomy is performed. Depending on the location of the lesion a medial or lateral malleolar osteotomy may be performed to gain access (over 70% of the cases) to the location. The osteochondral defect is debrided and prepared for transplantation. The donor site is visualized requiring an arthroscopy or arthrotomy of the knee. The harvesting device is carefully directed into the medial or lateral femoral condyle or the intercondylar notch of the knee. Exact perpendicularity of the harvest device to the articular surface is mandatory. Once the tissue is harvested from the knee, the ankle recipient site is prepared with an appropriate sized drill to match the harvested tissue. The harvested osteochondral graft is then inserted into the articular surface defect which was "standardized" with the drill. Great care is taken to correctly orient the osteochondral autograft as it is forced into the original osteochondral defect. Once correctly placed, the procedure is repeated until the defect is filled or the available donor tissue is exhausted. The tourniquet is deflated and hemostasis is achieved. The wounds are irrigated, the knee arthrotomy or arthrosopic portals are sutured, the malleolar osteotomy is reduced and repaired with screws or a plate and screws and the ankle incisions are sutured.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.

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

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

* monitor ROM and morbidity at donor site?

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD; William Beach, MD; Lloyd Smith, MD					
Specialty(s):	AAOS, APMA, AOFAS					
CPT Code:	28446					
Sample Size: 250	**Resp N:** 31	**Response:** 12.4 %				
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**4.00**	5.00	15.00
Survey RVW:		10.00	13.75	**16.00**	17.50	21.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		35.00	90.00	**90.00**	120.00	180.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x **1.0**	99232x	99233x		
Discharge Day Mgmt:	**0.0**	99238x **1.00**	99239x			
Office time/visit(s):	**0.0**	99211x	12x **3.0**	13x **3.0**	14x	15x
Prolonged Services:	**0.0**	99354x	55x	56x	57x	

CPT Code: 28446

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 28446		
		Specialty Recommended
Physician Work RVU:		17.50
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	101.0	99211x 0.0 12x 2.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29892	090	10.07	RUC Time

CPT Descriptor Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 29.0 %

TIME ESTIMATES (Median)	CPT Code: 28446	Key Reference CPT Code: 29892	Source of Time RUC Time
Median Pre-Service Time	65.00	10.00	
Median Intra-Service Time	120.00	90.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	30.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	101.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**339.00**	**261.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.89	3.63
Urgency of medical decision making	2.56	2.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.44	4.13
Physical effort required	3.78	3.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.63
Outcome depends on the skill and judgment of physician	4.44	4.13

Estimated risk of malpractice suit with poor outcome	3.56	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.22	3.00
Intra-Service intensity/complexity	4.44	4.00
Post-Service intensity/complexity	3.00	3.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation: *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
A survey was sent to orthopaedic surgeons representing foot and ankle surgeons, podiatrists, orthopaedic trauma, and general orthopaedics. A consensus panel of experts representing podiatry and orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic and podiatric services.

The panel felt the median RVW of 16.00 and intra-service time of 90 minutes were both too low for this procedure. Typically, we believe the median values represent a fair estimate, but our consensus panel, which consisted of multiple surgeons and physicians from multiple specialties all agreed the 75th percentile survey RVW of 17.50 and intra-service times of 120 were the correct values and appropriately valued the work involved in this procedure. These values, along with a hospital visit of 99231 and a discharge day, 99238 and two 99213 and two 99212 office visits, yield an appropriate approximation of the work in the procedure. The median experience of our survey respondents was 4, and given that, we felt the expert consensus panel should look more closely at the complexity of the procedure.

This code is actually three procedures in one.
1. Malleolar osteotomy and repair
2. Osteochondral transplantation of the talus
3. Harvesting of the osteochondral grafts from the knee

In looking at the work RVW for similar procedures such as 29874-Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation) Work RVW= 7.10; 28446 Similar to 29866 Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft) Work RVW recommendation = 14.48; and 27705- Osteotomy; tibia Work RVW= 10.74. If these three procedures are billed separately with appropriate modifier reductions, the total work RVW equals 23.40 [14.48 + (7.10 x 50%) + (10.74 x 50%)]. Given these values, we believe a work RVW of 17.50 is an appropriate value for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27705, 27707

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

Specialty AAOS How often? Sometimes

Specialty APMA How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 2000 Percentage %

Specialty APMA Frequency 1000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 1000 Percentage %

Specialty APMA Frequency 500 Percentage %

ecialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 28445, Open treatment of talus fracture, with or without internal or external fixation (work RVU = 17.07). The key reference service requires significantly less physician intra-service time and less intensity and complexity. The RUC determined that 28445 was a more appropriate PLI crosswalk as it requires a similar amount of intra-service time and has a similar work RVU as the recommended work RVU for the surveyed service.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

28446: Open osteochondral autograft, talus (includes obtaining graft[s])

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 35 (office) and 60 (facility) minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

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

The standard 6 minutes has been applied for the outpatient procedures for discharge day management services from the facility.

The standard 12 minutes has been applied for the inpatient procedure for discharge day management services from the facility.

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E
1				28446	
2	Meeting Date: April 2007 AMA/Specialty Society RVS Update Recommendation			Open osteochondral autograft, talus (includes obtaining graft[s])	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	228
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	162
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	**End: When patient enters office/facility for surgery/procedure**				
18	SERVICE PERIOD				
19	**Start: When patient enters office/facility for surgery/procedure**				
20	**Pre-service services**				
21	Review charts				
22	Greet patient and provide gowning				
23	Obtain vital signs				
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies				
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV				
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure				
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff				
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	/coordinate office visits /prescriptions				
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		6
41	**End: Patient leaves office/FACILITY**				
42	POST-SERVICE Period				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes	L037D	27		2
49	99213 36 minutes	L037D	36		3
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53	*Total Office Visit Time*			0	162
54	Other Activity (please specify)				
55	**End: with last office visit before end of global period**				
56	MEDICAL SUPPLIES	CMS Code	Unit		
57	pack, minimum multi-specialty visit	SA048	pack		4
58	pack, post-op incision care (suture)	SA054	kit		
59	drape, sterile, three-quarter sheet	SB014	item		
60	gloves, non-sterile	SB022	pair		
61	underpad 2ft x 3ft (Chux)	SB044	item		
62	Equipment	CMS Code			
63	table, power	EF031	100%		117
64	light, exam	EQ168	100%		117

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Arthroscopic Biceps Tenodesis

In February 2007, the CPT Editorial Panel created a new Category I CPT code, 29828, *Arthroscopy, shoulder, surgical; capsulorrhaphy; biceps tendonesis*, to describe a closed surgical process utilizing arthroscopic technique for biceps tendonesis. Prior to the introduction of this new coding, only open biceps tendonesis was described in CPT, despite increasing utilization of the closed arthroscopic technique.

The RUC reviewed the specialty societies' survey results describing the physician work for CPT code 29828. The RUC also reviewed the surveyed service in comparison to the key reference service, CPT code 29807, *Arthroscopy, shoulder, surgical; repair of SLAP lesion* (work RVU = 14.48). While the survey data were reliable, the specialty societies and the RUC agreed that the survey median work RVU was too high, as the surveyed service requires less time and is not more intense than the reference service. In comparison to the key reference service, the surveyed service contains slightly less intra-service and post-service time (intra = 75 and 20 minutes compared to post = 90 and 30 minutes, respectively) while the intensity and complexity measures between the two services were very similar in all categories assessed. The RUC concurred that the 25th percentile of the survey data (13.00 work RVUs) was more appropriate and accurately reflected the time and intensity involved in performing the service, especially when compared to the key reference service, code 29807.

The RUC recommends the survey's 25th percentile work RVU of 13.00 for code 29828.

Practice Expense

The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

New Technology

Because the service was developed relatively recently and at the request of the specialty society, **the RUC recommends that code 29828 be added to the New Technology list**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
23430		Tenodesis of long tendon of biceps (For arthroscopic biceps tenodesis, use 29828)	090	10.05 (No Change)
Surgery **Musculoskeletal System** **Endoscopy/Arthroscopy**				
29806		Arthroscopy, shoulder, surgical; capsulorrhaphy	090	14.95 (No Change)
29827		with rotator cuff repair	090	15.44 (No Change)
●29828	BB1	biceps tenodesis (Do not report 29828 in conjunction with 29805, 29820, 29822) (For open biceps tenodesis, use 23430)	090	13.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29828 Tracking Number BB1 Specialty Society Recommended RVU: **13.00**
Global Period: 090 RUC Recommended RVU: **13.00**

CPT Descriptor: Arthroscopy, shoulder, surgical; biceps tenodesis

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CLINICAL DESCRIPTION OF SERVICE:

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

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

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available, including positioning of monitors and arthroscopic/video equipment
- Monitor/assist with patient positioning - position the patient supinely and apply a shoulder boom to support the arm and allow the appropriate amount and angle of traction. Roll the patient into the lateral decubitus position and place pads to protect areas from pressure
- Indicate areas of skin to be prepped and mark surgical incisions
- Scrub and gown
- Perform surgical "time out" with operating surgical team

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

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

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

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD; William Beach, MD					
Specialty(s):	AAOS, AANA, ASES					
CPT Code:	29828					
Sample Size:	150	**Resp N:**	55	**Response:** 36.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	5.00	**10.00**	20.00	60.00
Survey RVW:		9.00	13.00	**14.50**	15.00	20.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		40.00	60.00	**75.00**	90.00	120.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**78.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 29828	
	Specialty Recommended
Physician Work RVU:	13.00
Pre-Service Evaluation Time:	40.0
Pre-Service Positioning Time:	15.0
Pre-Service Scrub, Dress, Wait Time:	15.0
Intra-Service Time:	75.00

Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	78.0	99211x 0.0 12x 2.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29807	090	14.48	RUC Time

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

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 58.1 %

TIME ESTIMATES (Median)

	CPT Code: 29828	Key Reference CPT Code: 29807	Source of Time RUC Time
Median Pre-Service Time	70.00	55.00	
Median Intra-Service Time	75.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**262.00**	**272.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.34	3.26
Urgency of medical decision making	2.27	2.35

Technical Skill/Physical Effort (Mean)

Technical skill required	4.28	4.09
Physical effort required	3.44	3.28

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.78	2.81
Outcome depends on the skill and judgment of physician	4.03	4.04
Estimated risk of malpractice suit with poor outcome	3.03	2.94

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.28	3.23
Intra-Service intensity/complexity	3.91	3.75
Post-Service intensity/complexity	2.88	2.87

Additional Rationale

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

A survey was sent to orthopaedic surgeons representing general orthopaedics, arthroscopy, and shoulder & elbow surgery. A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic services. The panel agreed that the SLAP procedure may require slightly more intra time (90 vs 75 minutes). The panel also agreed that that the total work for the survey code would be less than the reference code. Based on this discussion, the survey 25th percentile RVW of 13.00 is recommended. This value correctly sets this new code slightly less than the reference code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999 or 23430

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

Specialty AAOS How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Surgery Frequency 500 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate of Requestor

Specialty Orthopaedic Surgery Frequency 150 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

29828 Arthroscopy, shoulder, surgical; biceps tenodesis

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

A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey code relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

The standard 6 minutes has been applied for this outpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedures each have 2 x 99212 and 2 x 99213 visit. The standard times have been applied for post-service clinical labor time.

	A	B	C	D	E
1				29828	
2	**Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation**			**Arthroscopy, shoulder, surgical; biceps tenodesis**	
3	**LOCATION**	**Code**	**Staff Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**N/A**	**90**
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**192**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**60**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**6**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**126**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA		**5**
12	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA		**20**
13	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**
14	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**20**
15	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**7**
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
39	Discharge day management 99238 --12 minutes 99239 --15 minutes	**L037D**	RN/LPN/MTA		**6**
41	**End: Patient leaves office/FACILITY**				
42	**POST-SERVICE/Period 1**				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes	**L037D**	27		**2**
49	99213 36 minutes	**L037D**	36		**2**
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53					
54	*Total Office Visit Time*			**0**	**126**
55	Other Activity (please specify)				
56	**End: with last office visit before end of global period**				
57	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
58	pack, minimum multi-specialty visit	**SA048**	**pack**		**4**
59	pack, post-op incision care (suture)	**SA054**	**kit**		**1**
60					
61					
62	**Equipment**	**CMS Code**	**Utilization Percentage**		
63	table, power	**EF031**	**100%**		**126**
64	light, exam	**EQ168**	**100%**		**126**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Subtalar Arthroscopy

In February 2007, the CPT Editorial Panel created four new Category I CPT codes to describe procedures not previously included in CPT for arthroscopy of subtalar joints.

29904
The RUC reviewed the specialty societies' survey results and presentation for 29904, *Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body*. The RUC considered the surveyed code in comparison to the key reference service selected by two-thirds of the survey respondents, 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47). The RUC noted that the intra-service times are identical (60 minutes), however, the intensity and complexity required to perform the surveyed code is less than the reference service. Particularly, the reference service requires slightly greater mental effort and judgment as well as greater psychological stress. The RUC agreed with the specialty societies, that in light of this comparison, the survey median work RVU of 9.47 was too high. The RUC concurred that the 25th percentile work RVU of 8.50 was appropriate and was an accurate valuation of the work involved to perform the service.

The RUC recommends the 25th percentile work RVU 8.50 for code 29904.

29905
The RUC reviewed the specialty societies' survey results and presentation for 29905, *Arthroscopy, subtalar joint, surgical; with synovectomy*. The RUC considered the surveyed code in comparison to the key reference service 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47). The RUC noted that the intra-service times are identical (60 minutes), however, the intensity and complexity required to perform the surveyed code is only slightly less than the reference service. Particularly, the reference service requires slightly greater mental effort and judgment as well as greater psychological stress. The RUC agreed with the specialty societies, that in light of this comparison, the survey median work RVU of 10.00 was too high. The RUC concurred that the 25th percentile work RVU of 9.00 was appropriate and was an accurate valuation of the work involved to perform the service and maintained proper rank order within the family of services.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC recommends the 25th percentile work RVU 9.00 for code 29905.

29906

The RUC reviewed the specialty societies' survey results and presentation for 29906, *Arthroscopy, subtalar joint, surgical; with debridement*. The RUC considered the surveyed code in comparison to the key reference service 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47). The RUC noted that the intra-service times are identical (60 minutes), however, the intensity and complexity required to perform the surveyed code is nearly identical to the reference service. As such, the RUC agreed with the specialty societies, that in light of the close comparison and relativity with the reference service, the survey median work RVU of 10.00 was too high. The RUC concurred that the 25th percentile work RVU of 9.47, identical to the reference service, was appropriate as well as an accurate valuation of the work involved to perform the service and maintained proper rank order within the family of services.

The RUC recommends the 25th percentile work RVU 9.47 for code 29906.

29907

The RUC reviewed the specialty societies' survey results and presentation for 29907, *Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis*. The RUC considered the surveyed code in comparison to the key reference service 29899, *Arthroscopy Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis* (work RVU = 15.21). The RUC noted that the reference service contains significantly more intra-service time than the surveyed code (120 minutes versus 90 minutes). In addition, the pre- and post-service times are slightly greater in the reference code as compared to the surveyed code (pre = 75 versus 65 minutes and post = 30 versus 15 minutes, respectively). However, the intensity and complexity required to perform the surveyed code is very comparable to the reference service. The surveyed code requires greater technical skill, physical effort, psychological stress, and greater intensity/complexity in pre-, intra-, and post-service times compared to the reference service. Given the similarities in intensity and complexity, but differences in time, the RUC agreed that the survey median of 14.00 work RVUs was too high and believed that the 25th percentile work RVU of 12.00 appropriately accounted for the physician work involved in the service. The RUC did not agree with the number of hospital visits included within the service's global period. Because the service is typically performed without an extensive hospital stay, a 99231 visit in addition to the full 99238 discharge day management visit was excessive. The specialty agreed and the RUC recommended removing the 99231 hospital visit.

The RUC recommends the 25th percentile work RVU 12.00 for code 29907.

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Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility-only procedures as they are standard 090 day global inputs. No practice expense is recommended in the non-facility setting. The attached PE spreadsheet reflects these issues.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●29904	CC1	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body	090	8.50
●29905	CC2	with synovectomy	090	9.00
●29906	CC3	with debridement	090	9.47
●29907	CC4	with subtalar arthrodesis	090	12.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29904 Tracking Number CC1 Specialty Society Recommended RVU: **8.50**
Global Period: 090 RUC Recommended RVU: **8.50**

CPT Descriptor: Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male with rheumatoid arthritis, develops pain in the subtalar joint as a result of synovitis that has been unresponsive to medical management. He is treated with an arthroscopic subtalar synovectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available, including positioning of monitors and arthroscopic/video equipment
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, the articular surfaces of the subtalar joint must be distracted to allow for visualization of the entire joint. Arthroscopic portals are established to access the 3 facets of the subtalar joint. The entire joint is visualized and explored identifying the loose body. The arthroscopic grasper used to remove the loose body is inserted. If the loose body is mobile, it may be immobilized by the insertion of a spinal needle, making retrieval less difficult. The loose body is removed. The joint is thoroughly irrigated to remove any remaining debris. The joint is inspected. The arthroscope is removed. The foot is positioned so that it will rest in a neutral plantigrade position with the heel in 5 to 10 degrees of valgus. It is important to assess the fact that the foot is plantigrade, and that the heel is in 5 to 10 degrees of valgus. The tourniquet is deflated, and the portals are closed in layers. A splint or ankle brace is typically applied.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
  Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD; William Beach, MD; Lloyd Smith, MD					
Specialty(s):	AAOS, AOFAS, APMA					
CPT Code:	29904					
Sample Size:	200	**Resp N:**	59	**Response:** 29.5 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**2.00**	4.00	30.00
Survey RVW:		4.50	8.50	**9.47**	10.25	18.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		15.00	45.00	**60.00**	73.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x	99232x	99233x		
Discharge Day Mgmt:	**0.0**	99238x **0.50**	99239x			
Office time/visit(s):	**0.0**	99211x	12x	13x **3.0**	14x	15x
Prolonged Services:	**0.0**	99354x	55x	56x	57x	

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

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 29904	
	Specialty Recommended
Physician Work RVU:	8.50
Pre-Service Evaluation Time:	40.0
Pre-Service Positioning Time:	15.0
Pre-Service Scrub, Dress, Wait Time:	10.0
Intra-Service Time:	60.00

Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	69.0	99211x 0.0 12x 0.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29891	090	9.47	RUC Time

CPT Descriptor Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect

KEY MPC COMPARISON CODES:

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 40 **% of respondents:** 67.7 %

TIME ESTIMATES (Median)	CPT Code: 29904	Key Reference CPT Code: 29891	Source of Time RUC Time
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	15.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	69.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**228.00**	**227.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.35	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.45
Urgency of medical decision making	2.30	2.58
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.15	4.03
Physical effort required	3.15	3.35
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.83	2.90
Outcome depends on the skill and judgment of physician	3.78	3.94

Estimated risk of malpractice suit with poor outcome	2.70	2.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.05	3.20
Intra-Service intensity/complexity	3.58	3.60
Post-Service intensity/complexity	2.43	2.80

Additional Rationale

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

A survey was sent to orthopaedic surgeons representing foot and ankle surgeons, podiatrists, orthopaedic trauma, orthopaedic sports and medicine, and general orthopaedics. A consensus panel of experts representing podiatry and orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic and podiatric services.

The consensus panel reviewed the survey data and agreed that the most commonly cited reference code, 29891 was very similar in terms of total time, but that 29904 is relatively less intense and complex. Therefore, the consensus panel recommends the 25th percentile RVW of 8.50 which maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family, all of which represent more complex procedures. The panel felt the survey recommended times for 29904 are all appropriate and accurate but the median RVW of 9.47 would be inappropriate. The panel also felt that a half day discharge day (reference code has no discharge day but this procedure will be performed initially in the facility and require a half day discharge) and four post-operative office visits are typical for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999

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

Specialty AAOS How often? Sometimes

Specialty APMA How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 3000 Percentage %

Specialty APMA Frequency 2000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 1500 Percentage %

Specialty APMA Frequency 1000 Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

f no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29905 Tracking Number CC2 Specialty Society Recommended RVU: **9.00**
Global Period: 090 RUC Recommended RVU: **9.00**

CPT Descriptor: Arthroscopy, subtalar joint, surgical; with synovectomy

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male with rheumatoid arthritis, develops pain in the subtalar joint as a result of synovitis that has been unresponsive to medical management. He is treated with an arthroscopic subtalar synovectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available, including positioning of monitors and arthroscopic/video equipment
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, the articular surfaces of the subtalar joint must be distracted to allow for visualization of the subtalar joint, its capsule and the synovial lining. Arthroscopic portals are established to access the 3 facets of the subtalar joint and the synovial lining. The entire joint is visualized and explored identifying all diseased and hypertrophic synovium. The arthroscopic shaver is inserted and is used to excise and remove the abnormal synovium. After completion of the synovectomy, hemostasis is achieved and the joint is thoroughly irrigated to remove any remaining debris. The joint is inspected. The arthroscope is removed. The foot is positioned so that it will rest in a neutral plantigrade position with the heel in 5 to 10 degrees of valgus. It is·important to assess the fact that the foot is plantigrade, and that the heel is in 5 to 10 degrees of valgus. The tourniquet is deflated, and the portals are closed in layers. A splint or ankle brace is typically applied..

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	R. Dale Blasier, MD; William Beach, MD; Lloyd Smith, MD				
Specialty(s):	AAOS, AOFAS, APMA				
CPT Code:	29905				
Sample Size: 200	**Resp N:** 59	**Response:** 29.5 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**2.00**	5.00	40.00
Survey RVW:	5.00	9.00	**10.00**	12.00	18.00
Pre-Service Evaluation Time:			**40.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	15.00	60.00	**60.00**	90.00	120.00
Immediate Post Service-Time:	**15.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**			
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 29905	
	Specialty Recommended
Physician Work RVU:	9.00
Pre-Service Evaluation Time:	40.0
Pre-Service Positioning Time:	15.0
Pre-Service Scrub, Dress, Wait Time:	10.0
Intra-Service Time:	60.00

Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29891	090	9.47	RUC Time

CPT Descriptor Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 64.4 %

TIME ESTIMATES (Median)	CPT Code: 29905	Key Reference CPT Code: 29891	Source of Time RUC Time
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	15.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	85.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**244.00**	**227.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.37	3.45
Urgency of medical decision making	2.21	2.48
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.16	4.03
Physical effort required	3.08	3.19
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.87	2.90
Outcome depends on the skill and judgment of physician	3.97	4.06

Estimated risk of malpractice suit with poor outcome	2.66	2.81

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	3.13
Intra-Service intensity/complexity	3.63	3.63
Post-Service intensity/complexity	2.42	2.73

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
A survey was sent to orthopaedic surgeons representing foot and ankle surgeons, podiatrists, orthopaedic trauma, orthopaedic sports and medicine, and general orthopaedics. A consensus panel of experts representing podiatry and orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic and podiatric services.

The consensus panel reviewed the survey data and agreed that the most commonly cited reference code, 29891 was a good reference code and that 22905 is slightly more work and more time that 29891. Thus we recommend the survey median RVW of 10.00 as the correct value for this procedure. We believe this maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family, all of which represent more complex procedures. The panel felt the survey recommended times for 29905 are all appropriate and accurate and that a half day discharge day (reference code has no discharge day but this procedure will be performed initially in the facility and require a half day discharge) and four post-operative office visits are typical for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain) _

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAOS How often? Sometimes

Specialty APMA How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 3000 Percentage %

Specialty APMA Frequency 2000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 1500 Percentage %

Specialty APMA Frequency 1000 Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29906 Tracking Number CC3 Specialty Society Recommended RVU: **9.47**
Global Period: 090 RUC Recommended RVU: **9.47**

CPT Descriptor: Arthroscopy, subtalar joint, surgical; with debridement

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year old male develops a painful chondral lesion without associated deformity. He is treated with an arthroscopic debridement.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available, including positioning of monitors and arthroscopic/video equipment
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, the articular surfaces of the subtalar joint must be distracted to allow for visualization of the entire joint. Arthroscopic portals are established to access the 3 facets of the subtalar joint. The arthroscope and a high-speed arthroscopic abrader to remove the degenerative articular cartilage are inserted. After adequate visualization is established, the articular cartilage is removed from its location on the superior calcaneus or the inferior talus utilizing a high-speed burr and direct arthroscopic visualization to produce two smooth, articulating surfaces. After complete removal of the diseased articular cartilage, hemostasis is achieved and the joint is thoroughly irrigated to remove any remaining debris. The joint is inspected. The arthroscope is removed. The foot is positioned so that it will rest in a neutral plantigrade position with the heel in 5 to 10 degrees of valgus. It is important to assess the fact that the foot is plantigrade, and that the heel is in 5 to 10 degrees of valgus. The tourniquet is deflated, and the portals are closed in layers. A splint or ankle brace is typically applied.

Description of Post-Service Work: Post-service work: in facility
- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD; William Beach, MD; Lloyd Smith, MD					
Specialty(s):	AAOS, AOFAS, APMA					
CPT Code:	29906					
Sample Size:	200	**Resp N:** 37	**Response:** 18.5 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**1.00**	5.00	30.00
Survey RVW:		5.00	9.47	**10.00**	10.50	16.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		15.00	60.00	**60.00**	90.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 29906		
		Specialty Recommended
Physician Work RVU:		9.47
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	85.0	99211x 0.0 12x 1.0 13x 3.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29891	090	9.47	RUC Time

CPT Descriptor Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 72.9 %

TIME ESTIMATES (Median)	CPT Code: 29906	Key Reference CPT Code: 29891	Source of Time RUC Time
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	15.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	85.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**244.00**	**227.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.27
Urgency of medical decision making	2.41	2.54
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.96	3.85
Physical effort required	3.19	3.19
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.74	3.81

Estimated risk of malpractice suit with poor outcome	3.04	3.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.15	3.24
Intra-Service intensity/complexity	3.59	3.68
Post-Service intensity/complexity	2.56	2.76

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A survey was sent to orthopaedic surgeons representing foot and ankle surgeons, podiatrists, orthopaedic trauma, orthopaedic sports and medicine, and general orthopaedics. A consensus panel of experts representing podiatry and orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic and podiatric services.

The consensus panel reviewed the survey data and agreed that the most commonly cited reference code, 29891 was a good reference code and that 29906 is slightly more work and more time that 29891. Thus we recommend the survey median RVW of 10.00 as the correct value for this procedure. We believe this maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family, all of which represent more complex procedures. The panel felt the survey recommended times for 29906 are all appropriate and accurate and that a half day discharge day (reference code has no discharge day but this procedure will be performed initially in the facility and require a half day discharge) and four post-operative office visits are typical for this procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAOS How often? Sometimes

Specialty APMA How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 3000 Percentage %

Specialty APMA Frequency 2000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 1500 Percentage %

Specialty APMA Frequency 1000 Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29907 Tracking Number CC4 Specialty Society Recommended RVU: **12.00**
Global Period: 090 RUC Recommended RVU: **12.00**

CPT Descriptor: Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male develops subtalar pain due to advanced degenerative arthritis which has failed medical management. He is treated with an arthroscopic subtalar arthrodesis.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available, including positioning of monitors and arthroscopic/video equipment
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, the articular surfaces of the subtalar joint must be distracted to allow for visualization of the entire joint. Arthroscopic portals are established to access the 3 facets of the subtalar joint. The arthroscope and a high-speed arthroscopic abrader to remove the degenerative articular cartilage are inserted. After adequate visualization is established, all of the cartilage is removed from the adjacent talar and calcaneal articular surfaces. The normal inclination and alignment of the subtalar joint must be restored by sufficient bone sculpting to allow for "mating" of the opposing surface to achieve osseous stability. Provisional stabilization is inserted, usually percutaneously and radiographs are visualized to confirm position of the implants and alignment of the foot and subtalar joint. Definitive internal fixation is inserted, usually compression screws to maintain the desired osseous alignment and the provisional fixation is removed. Allograft is added to fill any osseous voids where the joint surfaces did not oppose each other congruently. Hemostasis is achieved and the joint is thoroughly irrigated to remove any remaining debris. The joint is inspected. The arthroscope is removed. The foot is positioned so that it will rest in a neutral plantigrade position with the heel in 5 to 10 degrees of valgus. It is important to assess the fact that the foot is plantigrade, and that the heel is in 5 to 10 degrees of valgus. The tourniquet is deflated, and the portals are closed in layers. A splint or ankle brace is typically applied.

Description of Post-Service Work: Post-service work: in facility

- Application of bulky dressing and short leg splint
- Monitor patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Monitor physical therapy
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	R. Dale Blasier, MD; William Beach, MD; Lloyd Smith, MD					
Specialty(s):	AAOS, AOFAS, APMA					
CPT Code:	29907					
Sample Size:	200	**Resp N:** 37	**Response:** 18.5 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	1.00	10.00
Survey RVW:		9.47	12.00	**14.00**	15.75	20.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		20.00	75.00	**90.00**	120.00	180.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**20.0**	99231x **1.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**38.0**	99238x **1.00**	99239x **0.00**			

CPT Code: 29907

Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 29907		
		Specialty Recommended
Physician Work RVU:		**12.00**
Pre-Service Evaluation Time:		**40.0**
Pre-Service Positioning Time:		**15.0**
Pre-Service Scrub, Dress, Wait Time:		**10.0**
Intra-Service Time:		**90.00**
Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29899	090	15.21	**RUC Time**

CPT Descriptor Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 1				
MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 2				

Other Reference CPT Code	Global	-	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 43.2 %

TIME ESTIMATES (Median)	CPT Code: 29907	Key Reference CPT Code: 29899	Source of Time RUC Time
Median Pre-Service Time	65.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**293.00**	**395.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.50
Urgency of medical decision making	2.43	2.46
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.79	4.50
Physical effort required	4.00	3.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.93	3.86
Outcome depends on the skill and judgment of physician	4.36	4.36
Estimated risk of malpractiee suit with poor outcome	3.64	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.29	3.23
Intra-Service intensity/complexity	4.50	4.31
Post-Service intensity/complexity	3.21	3.15

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A survey was sent to orthopaedic surgeons representing foot and ankle surgeons, podiatrists, orthopaedic trauma, orthopaedic sports and medicine, and general orthopaedics. A consensus panel of experts representing podiatry and orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, sports medicine) reviewed the survey data compared with the reference code and other orthopaedic and podiatric services.

The consensus panel reviewed the survey data and agreed that the most commonly cited reference code, 29899 was a good reference code and that 29907 is slightly less work and less time than 29899. Thus we recommend the survey median RVW of 14.00 as the correct value for this procedure. We believe this maintains appropriate relativity with the reference code, as well as with the other new procedure codes within this family, all of which represent more complex procedures. The panel felt the survey recommended times for 29907 are all appropriate and accurate and that an overnight facility stay along with a full discharge day and four post-operative office visits are typical for this procedure. Further, the post-operative visit package maintains relativity with our comparison code which has an additional in-facility stay visit and one higher level office visit (4-99213 for 29899 compared to 29907 which has 3-99213 and 1-99212).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAOS How often? Sometimes

Specialty APMA How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 3000 Percentage %

Specialty APMA Frequency 2000 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate of Requestor

Specialty AAOS Frequency 1500 Percentage %

Specialty APMA Frequency 1000 Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

29904: Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body

29905: Arthroscopy, subtalar joint, surgical; with synovectomy

29906: Arthroscopy, subtalar joint, surgical; with debridement

29907: Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
A consensus panel of experts representing orthopaedic subspecialty societies (general orthopaedics, arthroscopy, trauma, shoulder and elbow, hand, hip & knee, foot & ankle, total joint, sports medicine) reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

ase describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 35 (office) and 60 (facility) minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

Standard times for the activities necessary in the office and 100% of physician time were applied.

The standard 6 minutes has been applied for the outpatient procedures for discharge day management services from the facility.

The standard 12 minutes has been applied for the inpatient procedure for discharge day management services from the facility.

Post-Service Clinical Labor Activities:

The standard times have been applied for post-service clinical labor time.

	A	B	C	D	E	F	G	H	I	J	K
1				29904		29905		29906		29907	
2	April 2007 AMA/Specialty Society RVS Update Committee Recommendation	CMS		Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body		Arthroscopy, subtalar joint, surgical; with synovectomy		Arthroscopy, subtalar joint, surgical; with debridement		Arthroscopy, subtalar joint, surgical; with subtalar arthrod	
3	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			90	90	90	90	90	90	90	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA		174		201		201		201
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60		60		60		60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA		6		6		6		6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		108		135		135		135
9	PRE-SERVICE										
10	**Start: Following visit when decision for surgery or procedure made**										
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7		7
16	Other Clinical Activity (please specify)										
17	**End: When patient enters office/facility for surgery/procedure**										
18	SERVICE PERIOD										
19	**Start: When patient enters office/facility for surgery/procedure**										
20	**Pre-service services**										
21	Review charts										
22	Greet patient and provide gowning										
23	Obtain vital signs										
24	Provide pre-service education/obtain consent										
25	Prepare room, equipment, supplies										
26	Setup scope (non facility setting only)										
27	Prepare and position patient/ monitor patient/ set up IV										
28	Sedate/apply anesthesia										
29	**Intra-service**										
30	Assist physician in performing procedure										
31	**Post-Service**										
32	Monitor pt. following service/check tubes, monitors, drains										
33	Clean room/equipment by physician staff										
34	Clean Scope										
35	Clean Surgical Instrument Package										
36	Complete diagnostic forms, lab & X-ray requisitions										
37	Review/read X-ray, lab, and pathology reports										
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
39	Discharge day management 99238 –12 minutes	L037D	RN/LPN/MTA		6		6		6		6
40	Other Clinical Activity (please specify)										
41	**End: Patient leaves office/FACILITY**										
42	POST-SERVICE Period										
43	**Start: Patient leaves office/facility**										
44	Conduct phone calls/call in prescriptions										
45	*Office visits:*										
46	*List Number and Level of Office Visits*										
47	99211 16 minutes		16								
48	99212 27 minutes	L037D	27				1		1		1
49	99213 36 minutes	L037D	36		3		3		3		3
50	99214 53 minutes		53								
51	99215 63 minutes		63								
52	*Total Office Visit Time*				108		135		135		135
53	Other Activity (please specify)										
54	**End: with last office visit before end of global period**										
55	MEDICAL SUPPLIES		Unit								
56	pack, minimum multi-specialty visit	SA048	pack		3		4		4		4
57	pack, post-op incision care (suture)	SA054	kit						1		1
58	drape, sterile, three-quarter sheet	SB014	item								
59	gloves, non-sterile	SB022	pair								
60	underpad 2ft x 3ft (Chux)	SB044	item								
61	Equipment										
62	table, power	EF031	100%		117		117		126		126
63	light, exam	EQ168	100%		117		117		126		126

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Insert Emergency Airway

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 31500 *Intubation, endotracheal, emergency procedure* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they felt should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 31500 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 31500 to the RUC. Code 31500 had never been surveyed nor discussed at the RUC previously. The RUC understands that it is tasked with considering whether 31500 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 31500.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service had significant time in the pre-service and post service periods which would disqualify 31500 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

After significant discussion, the RUC determined that the specialty society recommended pre-service time did not accurately reflect the service and decreased it from 9 minutes to 4 mninutes, while retaining the post-operative time at 10 minutes. **Due to a detailed review of the pre-service and post-service time to ensure no duplication with other service performed on the same date, the RUC recommends that 31500 be retained on the Modifier -51 Exempt List.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

As the RUC works under the presumption that all services on the RBRVS are correctly valued unless evidence is produced to revalue, the specialty society provided compelling evidence to support its recommendation of 2.55 RVUs, which is an increase over the existing value of 31500, 2.33 RVUs. The RUC reviewed this compelling evidence and did not agree with the specialty that there had been changes in the techniques and methods of providing endotracheal intubation. **Therefore, the RUC recommends the new physician times, 4 minutes of pre-service time, 5 minutes of intra-service time and 10 minutes of post-service time associated with 31500 and that the existing value of 2.33 work RVUs be retained for this procedure.**

Practice Expense:
The RUC recommends that the practice expense inputs be retained for this procedure, which is no practice expense inputs in the facility or non-facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲⊘31500	DD2	Intubation, endotracheal, emergency procedure	000	2.33 (No Change)

982

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31500 Tracking Number DD2 Specialty Society Recommended RVU: **2.55**
Global Period: 000 RUC Recommended RVU: **2.33**

CPT Descriptor: Intubation, endotracheal, emergency procedure

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old man with coronary artery disease following failure of lithotripsy to relieve ureteral obstruction from a stone develops circulatory failure. The patient requires emergency endotracheal intubation for respiratory failure

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 65%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Evaluation of the patient's clinical condition, hemodynamics and assessment of airway anatomy. Equipment needed for tracheal intubation is determined and taken to the patient's bedside. The patient's directive regarding such intervention – if previously determined – is reviewed. Drugs required to facilitate manipulation of the airway are selected and prepared. Oxygen delivery system, resuscitation bag and mask and suction device are selected and checked for proper functioning. An attempt is made to explain the situation and anticipated procedure, reason for procedure to the patient and sometimes family. The patient is informed of benefits and possible complications and risks of procedure to the degree possible in view of the emergent nature of the situation.

Description of Intra-Service Work: The patient is positioned in the sniffing position. The patient receives oxygen via resuscitation bag and mask. Cricoid pressure is applied. Following confirmation of a clear airway, the drugs are administered for patient sedation and muscle relaxation. The laryngoscope is inserted into the airway and the vocal cords are identified. The appropriate size endotracheal tube is inserted into the trachea, the cuff is inflated and confirmation of the proper position is determined by clinical examination and capnography.

Description of Post-Service Work: The position of the endotracheal tube is confirmed by clinical examination and chest X-ray. The patient receives mechanical ventilatory support as appropriate to ensure both oxygenation and ventilation based on clinical status. The patient is observed until the physician is certain that ventilation is adequate. The physician confirms that the ETT remains in proper position after resuscitation or patient transfer to gurney or bed. A procedure note is written in the patient's chart as is an order for the chest x-ray. The physician reviews the chest x-ray for proper endotracheal tube placement and adjustments are made as necessary. An attempt is made to discuss the procedure and outcome with any patient family members that may be available on site.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Tripti Kataria, MD, MPH and James Perri, MD				
Specialty(s):	American Society of Anesthesiologists, American College of Emergency Physicians				
CPT Code:	31500				
Sample Size: 345	**Resp N:** 82	**Response:** 23.7 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	8.00	**20.00**	50.00	500.00

CPT Code: 31500

Survey RVW:		1.00	2.10	**2.75**	3.24	4.25
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**2.0**		
Pre-Service Scrub, Dress, Wait Time:				**2.0**		
Intra-Service Time:		1.00	4.00	**5.00**	10.00	25.00
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 31500		
		Specialty Recommended
Physician Work RVU:		2.55
Pre-Service Evaluation Time:		2.0
Pre-Service Positioning Time:		1.0
Pre-Service Scrub, Dress, Wait Time:		1.0
Intra-Service Time:		5.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31515	000	1.80	Harvard Time

CPT Descriptor Laryngoscopy, direct, with or without tracheoscopy; for aspiration

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
92950	000	87,707	3.79	Harvard Time

CPT Descriptor 1 Cardiopulmonary resuscitation (eg, in cardiac arrest)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
52000	000	976,556	2.23	RUC Time

CPT Descriptor 2 Cystourethroscopy (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 39.0 %

TIME ESTIMATES (Median)	CPT Code: 31500	Key Reference CPT Code: 31515	Source of Time Harvard Time
Median Pre-Service Time	4.00	14.00	
Median Intra-Service Time	5.00	26.00	
Median Immediate Post-service Time	10.00	14.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**19.00**	**54.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.00
Urgency of medical decision making	4.88	3.28
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.53	3.91
Physical effort required	3.88	3.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.75	3.75
Outcome depends on the skill and judgment of physician	4.69	3.78
Estimated risk of malpractice suit with poor outcome	4.44	3.84

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.59	2.84
Intra-Service intensity/complexity	4.34	3.63
Post-Service intensity/complexity	3.22	2.59

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code comes to the RUC as a result of the CPT review of codes listed in Appendix E – Summary of Codes Exempt from Modifier 51. The Panel agreed that the code met the criteria to remain in this appendix.

While 65% of our respondents indicated that moderate sedation was typical for this procedure, we maintain that it is not inherent to the procedure. We suspect that many of our respondents may have known that moderate sedation as defined by CPT was not what is actually provided in intubation, but deep sedation and temporary paralysis is necessary. This may have confused participants on how to respond to the question since that deep sedation is an important part of the service.

This was a joint survey between the two specialties that most frequently provide the service – Emergency Medicine and Anesthesia. The times from each specialty were very consistent:

	ACEP	ASA	All Responses
Pre-service time	10	8	9
Intra-service time	5	5	5
Post-service time	10	10	10

The Survey RVW was bi-modal; the ACEP median was 2.85 and the ASA median was 2.25. We are recommending a work RVU that falls between these two values – 2.55. We maintain that an increase is warranted because:

- There have been changes in practice since the code was first valued. In an emergency scenario, patients are intubated in the field. Our respondents noted that they intubate the most difficult patients that could not be successfully done in the filed. They also note that, in an emergency situation, the patient's oral airway may be filled with vomitus after a failed intubation or CPR.
- We compared the work/complexity/ intensity to that associated with code 52000 – Cystourethroscopy (separate procedure). This code is on the MPC list (status A) and has 2.23 work RVUs. An endotracheal intubation carries higher degrees of the all the components of physician work and should have a correspondingly higher value. We believe our recommended value of 2.55 is a reasonable reflection of this comparison.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) The service is on the Modifier 51 exempt list as it is typically provided adjunctive to another service or procedure.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The service could be provided to treat a patient who develops respiratory distress while undergoing another procedure. The treatment could involve other services and procedures after the airway is secure and adequate ventilation is established. These other servcies and procedures would include arterial lines (36620), pulmonary artery catheters (93503) and thoracentesis (32000).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31500

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Emergency Medicine	How often? Commonly
Specialty Anesthesia	How often? Commonly
Specialty Pulmonary Disease	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1086748
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Using the breakdown on file for the Medicare population:

Specialty Emergency Medicine	Frequency 433396	Percentage 39.88 %
Specialty Anesthesia	Frequency 248540	Percentage 22.87 %
Specialty Pulmonary Disease	Frequency 137585	Percentage 12.66 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 271,687 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Breakdown according to RUC Database

Specialty Emergency Medicine	Frequency 108349	Percentage 39.88 %

Specialty Anesthesia	Frequency 62136	Percentage 22.87 %
Specialty Pulmonary Disease	Frequency 34396	Percentage 12.66 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. The existing PLI for 31500 should be retained.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor: **31500 Intubation, endotracheal, emergency procedure**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACEP and ASA conducted a RUC survey for CPT code 31500, Intubation, endotracheal, emergency procedure, for use in the facility setting. The practice expense units were deemed to be unchanged and we are recommending keeping the current inputs of zero clinical labor minutes, no supplies and no equipment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **31500 – Intubation, endotracheal, emergency procedure**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACEP and ASA conducted a RUC survey for CPT code 31500, Intubation, endotracheal, emergency procedure, for use in the facility setting. The practice expense units were deemed to be unchanged and we are recommending keeping the current inputs of zero clinical labor minutes, no supplies and no equipment

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1							
2				31500		CPT Code	
3	Meeting Date: April 2007			Intubation, endotracheal, emergency procedure		Code Descriptor	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			0	0	0	0
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	SERVICE PERIOD						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	**Intra-service**						
31	Assist physician in performing procedure						
32	**Post-Service**						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 –12 minutes 99239 –15 minutes						
41	Other Clinical Activity (please specify)						
42	**End: Patient leaves office**						
43	POST-SERVICE PERIOD						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions						
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54							
55	*Total Office Visit Time*			0	0	0	0
56	Other Activity (please specify)						
57	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
2				31500		CPT Code	
3	Meeting Date: April 2007			Intubation, endotracheal, emergency procedure		Code Descriptor	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES	CMS Code	[illegible]				
59	No Supplies	SX007					
60							
61							
62							
63							
64							
65							
66	Equipment	CMS Code	[illegible]				
67	No Equipment	EZ007					
68							
69							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Add-on Maze Procedures

In 2006, the Society of Thoracic Surgeons (STS) brought forward new codes for the Maze procedures to account for the new technology and various techniques to perform Maze procedures. These codes, 33254 *Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)* (Work RVU=23.58), 33255 *Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass* (Work RVU=28.91), and 33256 *Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass* (Work RVU=34.77) were approved by CPT for the 2007 cycle and replaced code 33253 *Operative incisions and reconstruction of atria for treatment of atrial fibrillation or atrial flutter (eg, maze procedure)* (work RVU=31.01). During the valuation process at the RUC, it was determined that a significant number of these procedures were performed in conjunction with other cardiac procedures. As a result, the RUC determined that the new open codes for 2007 should not be reported with other cardiac procedures and asked CPT to add verbiage to the guidelines for the open Maze codes indicating that they should not be reported in addition to other cardiac procedures and to report this circumstance, the unlisted cardiac procedure code (33999) should be reported. The RUC suggested that add-on codes would allow appropriate valuation of these services. The CPT Editorial Panel, therefore, created three new add-on Maze codes to allow for reporting of these services with other cardiac procedures.

The specialty society utilized a standard RUC survey instrument and received survey responses from 70 thoracic surgeons. The survey data was reviewed by a consensus committee and was further supported by data from the STS Database. All of this data supported the notion made by the specialty that the patient in which these procedures are performed on, is a very intense, complicated patient with probable comorbities including congestive heart failure and cerebrovascular disease as these services would be performed in addition to other cardiac procedures including 33533 *Coronary artery bypass, using arterial graft(s); single arterial graft* (Work RVU=33.64). The specialty society explained that the complexity/severity of this patient justifies the pre-service and post-service times as well as post-operative visits not typically associated with other ZZZ global procedures and further justified that during the 2005 Five-Year Review precedents had been set that other ZZZ global codes within the cardiothoracic families received these additional times and visits. Additionally, the RUC had some concern that as these procedures are ZZZ global procedures, typically there would not be a discharge day-management procedure associated with them. The specialty society explained that the patients who would receive these procedures are very complex as they are receiving the add-on maze procedure in addition to another cardiac procedure. The additional half of the 99238 discharge day management procedure associated with these add-on maze procedures is a proxy as when a Maze procedure is performed with the base cardiac code, a level 99239 discharge day management procedure, would be typical for these patients. A RUC member did express concern regarding whether the CABG codes and other thoracic surgery services in the 2005 Five-Year Review included the Maze procedures in STS database time. The STS stated that the time in the STS database, as used in the 2005 Five-Year Review, only includes time for services where a single procedure was performed and would not reflect the additional time needed to perform the add-on Maze procedures.

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33257 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to the code for the primary procedure)*

The specialty society made revisions to the pre-service and post-service time, reducing both from 30 minutes to 15 minutes to more accurately reflect the services provided during these periods of time. The RUC reviewed 33257 in comparison to its reference code 33518 *Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)* (Work RVU=7.93). The RUC noted that the total service time for 332570 was longer than the reference code, 180.30 minutes and 112.60 minutes. Further, the RUC noted that the surveyed code is a more complex procedure to perform in comparison to the reference code. Therefore, the RUC recommends 9.63 work RVUs, the survey's 75th percentile, as this value appropriately places this service in comparison to the reference code. The RUC further noted that under current payment policy, when 33254, the stand- alone equivalent of this code, is performed with another cardiac procedure, it would be subject to the multiple procedure reduction and would be decreased by 50 percent, resulting in a value of 11.79 work RVUs which is substantially higher in value than the proposed recommended RVU of the add-on procedure. **The RUC recommends 9.63 work RVUs for 33257.**

33258 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass, (List separately in addition to the code for the primary procedure)*

The specialty society made revisions to the pre-service and post-service time, reducing both from 30 minutes to 15 minutes to more accurately reflect the services provided during these periods of time. The RUC reviewed 33258 in comparison to its reference code 33519 *Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)* (Work RVU=10.49). The RUC noted that the total service time for 33258 was longer than the reference code, 190.30 minutes and 139.80 minutes. Further, the RUC noted that the surveyed code is a more complex procedure to perform in comparison to the reference code. Therefore, the RUC recommends 11.00 work RVUs, the survey's 75th percentile, as this value appropriately places this service in comparison to the reference code. The RUC further noted that under current payment policy, when 33255, the stand- alone equivalent of this code, is performed with another cardiac procedure, it would be subject to the multiple procedure reduction and would be decreased by 50 percent, resulting in a value of 14.46 work RVUs which is substantially higher in value than the proposed recommended RVU of the add-on procedure. **The RUC recommends 11.00 work RVUs for 33258.**

33259 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition to the code for the primary procedure)*

The specialty society made revisions to the pre-service and post-service time, reducing both from 30 minutes to 15 minutes to more accurately reflect the services provided during these periods of time. The RUC reviewed 33259 in comparison to its reference code 33522 *Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)* (Work RVU=14.14). The RUC noted that the total service time for 33259 was comparable to the reference code, 222.70 minutes and 174.45 minutes. However, the RUC noted that the surveyed code requires similar complexity in comparison to the reference code. Therefore, the RUC recommends 14.14 work RVUs, the survey's

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75th percentile, as this value appropriately places this service in comparison to the reference code. The RUC further noted that under current payment policy, when 33256, the stand- alone equivalent of this code, is performed with another cardiac procedure, it would be subject to the multiple procedure reduction and would be decreased by 50 percent, resulting in a value of 17.39 work RVUs which is substantially higher in value than the proposed recommended RVU of the add-on procedure. **The RUC recommends 14.14 work RVUs for 33259.**

The RUC notes that its original assertion that Maze procedures performed in conjunction with other cardiac services be valued less than the 50% multiple surgery reduction is maintained with these recommendations.

Practice Expense:
The RUC recommends the standard cardiothoracic surgery 090 day global practice expense inputs package for 33257, 33258 and 33259.

New Technology:
The RUC recommends that 33257, 33258 and 33259 be added to the new technology list as this procedure utilizes new techniques.

999

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
This family of codes describes the surgical treatment of supraventricular dysrhythmias. Tissue ablation, disruption and reconstruction can be accomplished by many methods including surgical incision or through the use of a variety of energy sources (eg, radiofrequency, cryotherapy, microwave, ultrasound, laser). If excision or isolation of the left atrial appendage by any method, including stapling, oversewing, ligation, or plication, is performed in conjunction with any of the atrial tissue ablation and reconstruction (maze) procedures (33254-33256,33257, 33258, 33259, 33265-33266), it is considered part of the procedure. Codes 33254-33256 are only to be reported when there is no concurrently performed procedure that requires median sternotomy or cardiopulmonary bypass. The appropriate atrial tissue ablation add-on code, 33257, 33258, 33259 should be reported in addition to an open cardiac procedure requiring sternotomy or cardiopulmonary bypass if performed concurrently. ~~When 33254-33256 are performed with a concurrent procedure that requires a median sternotomy or cardiopulmonary bypass, report the operative (nonthoracoscopic) electrophysiologic procedure with unlisted procedure code 33999.~~ ***Definitions*** ***Limited** operative ablation...* *Surgical isolation of...* ***Extensive** operative ablation...*				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
1. The services included... *2. Additional ablation of ...*				
D 33253		~~Operative incisions and reconstruction of atria for treatment of atrial fibrillation or atrial flutter (eg, maze procedure)~~ (33253 has been deleted. To report, use 33254 - 33256)	090	Deleted for CPT 2007
33254		Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	090	23.58 (No Change)
33255		extensive (eg, maze procedure); without cardiopulmonary bypass	090	28.91 (No Change)
33256		with cardiopulmonary bypass (Do not report 33254-33256 in conjunction with 32020, 32100, 33120, 33130, 33210, 33211, 33400-33507, 33510-33523, 33533-33548, 33600-33853, 33860-33863, 33910-33920)	090	34.77 (No Change)
●✚33257	EE1	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to the code for the primary procedure) (Use 33257 in conjunction with 33120-33130, 33250-33251, 33261, 33300-33335, 33400-33496, 33500-33507, 33510-33516, 33533-33536, 33542-33548, 33600-33619, 33641-33697, 33702-33722, 33724-33732, 33735-33767, 33770-33781, 33786-33788, 33800-33814, 33840-33853, 33860-33877, 33910-33922, 33925-33926, 33935, 33945, 33975-33980)	ZZZ	9.63

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
●✚33258	EE2	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass, (List separately in addition to the code for the primary procedure) (Use 33258 in conjunction with 33130, 32350, 33300, 33310, 33320, 33321, 33330, 33332, 33401, 33414-33417, 33420, 33470-33472, 33501, 33502, 33503, 33510-33516, 3533-33536, 33690, 33735, 33737, 33800-33803, 33813, 33840-33852, 33915, 33925 when the procedure is done without cardiopulmonary bypass)	ZZZ	11.00
●✚33259	EE3	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition to the code for the primary procedure) (Use 33259 in conjunction with 33120, 33251, 33261, 33305, 33315, 33322, 33335, 33400, 33403, 33404, 33405-33410, 33411-33413, 33422, 33425-33430, 33460-33468, 33474-33478, 33496, 33500, 33504 - 33506, 33507, 33510-33516, 33533-33536, 33542-33548, 33600-33619, 33641-33688, 33692-33697, 33702-33722, 33730-33732, 33736, 33750-33767, 33770-33781, 33786-33788, 33814, 33853, 33860-33877, 33910, 33916, 33917, 33920, 33922, 33926, 33935, 33945, 33975-33980) (Use 33259 in conjunction with 33510-33516 and 33533-33536 for maze procedure performed in conjunction with coronary artery bypass grafting with cardiopulmonary bypass) (Do not report 33257, 33258 and 33259 in conjunction with 32020, 33210, 33211, 33254, 33255, 33256, 33265, 33266)	ZZZ	14.14

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33257 Tracking Number EE1 Specialty Society Recommended RVU: **9.63**
Global Period: ZZZ RUC Recommended RVU: **9.63**

CPT Descriptor: Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old man with hypertension and hyperlipidemia presents with unstable angina, rules out for myocardial infarction, and is found to have 3 vessel coronary disease with moderate LV dysfunction. He has had multiple episodes of atrial fibrillation but presents in sinus rhythm, on antiarrhythmic medications and with a slightly enlarged left atrium on echocardiography. At the time of his cardiac procedure, a limited operative tissue ablation and reconstruction of the atria (eg, modified maze procedure) is performed.
]

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Additional physician work includes review of the echocardiogram report with attention to left atrial size to determine that a limited, modified maze procedure is appropriate. Careful review of the patients arrhythmia history, including documentation of episodes of atrial fibrillation is also required.

Description of Intra-Service Work: A series of atrial lesions were created using an ablative energy source to isolate or redirect abnormal atrial depolarization site(s). The creation of these lesions requires sharp and blunt dissection of the pulmonary veins from the pericardial reflections, to ensure that the ablation energy is directed to the body of the left atrium rather than to the pulmonary veins themselves. Special attention is paid to ablative energy delivery to avoid injury to coronary arteries or the esophagus. The left atrial appendage is excised. Temporary atrial and ventricular pacing wires are placed.

Description of Post-Service Work: - Additional postoperative visits are typically required due to the paradoxically increased incidence of atrial flutter/fibrillation related to the add-on procedure and the need for prompt conversion to sinus rhythm to mitigate against persistence of atrial fibrillation. Antiarrhytmic drugs are typically required, and oral anticoagulation frequently needed. These aspects result in increased discharge management work and additional office visits.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Kirk Kanter, MD		
Specialty(s):	Society of Thoracic Surgeons		
CPT Code:	33257		
Sample Size:	300	**Resp N:** 70	**Response:** 23.3 %
Sample Type:	Random		

CPT Code: 33257

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	3.00	**10.00**	15.00	30.00
Survey RVW:		0.50	4.50	**6.83**	9.63	15.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	20.00	**30.00**	30.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**140.0**	99291x **2.0** 99292x **0.0**				
Other Hospital time/visit(s):	**80.0**	99231x **0.0** 99232x **2.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**48.0**	99211x **0.0** 12x **3.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 33257	
	Specialty Recommended
Physician Work RVU:	**9.63**
Pre-Service Evaluation Time:	**15.0**
Pre-Service Positioning Time:	**0.0**
Pre-Service Scrub, Dress, Wait Time:	**0.0**
Intra-Service Time:	**30.00**

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**44.8**	99291x **0.64** 99292x **0.0**
Other Hospital time/visit(s):	**33.5**	99231x **0.0** 99232x **0.0** 99233x **0.61**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33141	ZZZ	2.54	**RUC Time**

CPT Descriptor Transmyocardial laser revascularization, by thoracotomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**	

CPT Descriptor 1 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22842	ZZZ	12.56	**RUC Time**	

CPT Descriptor 2 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments

Other Reference CPT Code	Global	Work RVU	Time Source
33518	ZZZ	7.93	RUC Time

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 18.5 %

TIME ESTIMATES (Median)

	CPT Code: 33257	Key Reference CPT Code: 33141	Source of Time RUC Time
Median Pre-Service Time	15.00	0.00	
Median Intra-Service Time	30.00	19.00	
Median Immediate Post-service Time	15.00	0.00	
Median Critical Care Time	44.8	0.00	
Median Other Hospital Visit Time	33.5	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**180.30**	**19.00**	
Other time if appropriate		0.00	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.03	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.37	3.33
Urgency of medical decision making	2.65	3.09

Technical Skill/Physical Effort (Mean)

Technical skill required	3.48	3.53
Physical effort required	3.33	3.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.61	3.66

Outcome depends on the skill and judgment of physician	3.70	3.71
Estimated risk of malpractice suit with poor outcome	3.40	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.06	3.08
Intra-Service intensity/complexity	3.33	3.52
Post-Service intensity/complexity	3.09	3.03

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
X0

Additional Rationale:

The STS is recommending the 75th percentile value for 33257, rather than the median value which if used would result in insufficient intraservice intensity (IWPUT) or insufficient pre- and post service elements recommended by the survey respondents. It is clear, from reviewing the survey results, that the respondents allocated substantial additional pre- and post-service work elements, but failed to consider them in estimating the overall code value. In fact, 89% of the respondents assigned more work to pre- and post-services than they did to the total code work value.

Using the median responses for total RVW, intraservice time, and additional pre- and post-service time and visits results in an IWPUT of -0.297, in that the recommended pre- and post service work exceeds the total median survey RVW. Using the 75th percentile RVW, while retaining the same pre- and post-values, still results in an IWPUT of -0.201.

It is also clear from the survey results that, despite the instructions, many respondents did not understand that ZZZ pre- and post-service time and work should be additional to that already present in the base procedure. Accordingly, STS queried its National Cardiac Database for procedures in 2004, 2005 and 2006 where this procedure was performed as the sole additional procedure, in combination with any of 55 base procedural code or code combinations. 4,587 such procedures were identified, and compared to weighted average data from 356,560 patients having matching base procedures alone. The results are illustrated in the following table:

		Base Procedure	X0 Limited Maze Add on	Absolute Delta	Relative Delta
Number of Patients			4,587		
Age(Years)	Mean	62.8	68.1	5.3	8%
Age >= 65	%Yes	48.0%	67.2%	19.2%	40%
Gender (Male)	%Yes	61.6%	63.2%	1.6%	3%
Weight(kg)	Mean	83.1	85.1	1.9	2%

Diabetes	%Yes	25.7%	26.2%	0.5%	2%
PVD	%Yes	10.1%	11.9%	1.8%	18%
CVD	%Yes	11.4%	14.6%	3.2%	28%
Previous CV Intervention	%Yes	17.2%	20.0%	2.8%	16%
Previous PCI	%Yes	52.6%	55.1%	2.5%	5%
Congestive Heart Failure	%Yes	26.1%	35.8%	9.7%	37%
Cardiogenic Shock	%Yes	1.6%	0.8%	-0.8%	-50%
Ejection Fraction Delta	Mean	52.9	51.1	-1.9	-4%
Intraop Blood Products	%Yes	39.6%	43.2%	3.6%	9%
Postop Blood Products	%Yes	40.9%	46.1%	5.2%	13%
Total Hours Ventilated	Mean	17.1	20.6	3.4	20%
Total ICU Hours	Mean	57.5	71.4	13.8	24%
Post Operative LOS	Mean	6.9	8.1	1.2	17%
Mortality	%Yes	2.1%	3.3%	1.3%	60%
Readmisson <=30 Days	%Yes	9.9%	13.3%	3.4%	35%

These data unequivocally demonstrate that the use of 33257 identifies a population of patients that are significantly older and sicker than those not undergoing 33257 or any other concomitant procedure. The 37% increase in preoperative heart failure and 28% increase in cerebrovascular disease are consistent with the presence of atrial fibrillation and more advanced age (5.3 years per patient). These patient characteristics and the impact of 33257 performance result in 13.8 additional ICU hours per patient, and an additional 1.2 days of hospital stay. The patients receive more blood products, and are more to be readmitted to the hospital, and are less likely to survive.

These data confirm in the survey results regarding pre- and post-service additional work, and STS recommends using the method approved in the 2005 5-year review to allocate post-service in-hospital E&M fractional visits from these data. It should be stressed that the add-on maze patient data were not included in the 5 year review where multiple procedure patients were appropriately excluded from the analysis. Therefore, the additional resulting physician work is not included in the base procedure code values.

We also recommend reductions in the survey recommended pre-service time, post-service time, and outpatient office visits. The latter single additional visit is consistent with the known need to manage anti-arrhythmic agents, arrhythmias, and anticoagulation and is consistent with the 35% increase in hospital readmission rate. We recommend reduction of the recommended 99238 by 50%, which in effect will provide the patient with a 99239 discharge day when combined with the base code. This is consistent with the increased work associated with drug and drug interaction management and arrhythmia counseling and discharge planning.

Using these recommendations, with the 75th percentile survey RVW results in an IWPUT of 0.110, which is well within the range of previously approved IWPUT for cardiac surgery codes. We note that this value represents 41% of the stand alone 090 global version of the ZZZ code, less than the 50% reduction that would otherwise apply.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. Utilization Table for 33257 from STS Data
4. CPT code description CPT Code X0 Limited Maze
5. Coronary artery bypass, using arterial and venous grafts 33533-6 33517-23 2065 45.0%
6. Replacement, mitral valve, with cardiopulmonary bypass 33430 728 15.9%
7. Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction 33427 574 12.5%
8. Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve 33405 504 11.0%
9. Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring 33426 295 6.4%
10. Coronary artery bypass, vein only; three coronary venous grafts 33512 67 1.5%
11. Coronary artery bypass, using arterial graft(s) 33533-33536 33533 64 1.4%
12. Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve 33410 50 1.1%
13. Coronary artery bypass, vein only; two coronary venous grafts 33511 46 1.0%
14. Repair atrial septal defect, secundum, with cardiopulmonary bypass 33641 41 0.9%
15. Coronary artery bypass, vein only; four coronary venous grafts 33513 35 0.8%
16. Coronary artery bypass, vein only; single coronary venous graft 33510 18 0.4%
17. Valvuloplasty, mitral valve, with cardiopulmonary bypass; 33425 17 0.4%
18. Coronary artery bypass, vein only; five coronary venous grafts 33514 11 0.2%
19. Ascending aorta graft with aortic root replacement and coronary reconstruction 33863 8 0.2%
20. Replacement, tricuspid valve, with cardiopulmonary bypass 33465 7 0.2%
21. Valvuloplasty, tricuspid valve; with ring insertion 33464 6 0.1%
22. Valvuloplasty, tricuspid valve; with ring insertion 33464 6 0.1%
23. Valvuloplasty, aortic valve; open, with cardiopulmonary bypass 33400 5 0.1%
24. Coronary artery bypass, vein only; six or more coronary venous grafts 33516 4 0.1%
25. Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis 33415 2 0.0%
26. Replacement, pulmonary valve 33475 2 0.0%
27. Myocardial resection (eg, ventricular aneurysmectomy) 33542 2 0.0%
28. Repair of cardiac wound; without bypass 33300 2 0.0%
29. Valvuloplasty, tricuspid valve; without ring insertion 33463 1 0.0%
30. Repair of postinfarction ventricular septal defect, with or without myocardial resection 33545 1 0.0%
31. SVR 33548 1 0.0%
32. Insertion of ventricular assist device, implantable intracorporeal, single ventricle 33979 1 0.0%
33. Insertion of ventricular assist device, implantable intracorporeal, single ventricle 33979 1 0.0%
34.
35. Total 2.5 Years STS database 4587 100.0%
36.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33253

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4587

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The frequency was taken from the STS database and accounts for procedues done over a 2.5 year period of time.

Specialty cardiothoracic surgery Frequency 4587 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,522 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The STS database mean age is over 65 so it is estimated that approximately 55% of these procedures are performed in the Medicare population

Specialty cardiothoracic surgery Frequency 2522 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. The procedure that best reflects the PLI is the 33518 Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33258 Tracking Number EE2 Specialty Society Recommended RVU: **11.00**
Global Period: ZZZ RUC Recommended RVU: **11.00**

CPT Descriptor: Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old man with hypertension and hyperlipidemia presents with unstable angina, rules out for myocardial infarction, and is found to have 3 vessel coronary disease with moderate LV dysfunction. He also has chronic atrial fibrillation requiring anticoagulation, and an echocardiogram shows a markedly enlarged left atrium. At the time of his cardiac procedure, an extensive operative tissue ablation and reconstruction of atria (eg, maze procedure) is performed without cardiopulmonary bypass.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: - Additional physician work includes review of the echocardiogram report with attention to left atrial size to determine that a formal, extensive maze procedure is appropriate. Careful review of the patients arrhythmia history, including documentation of the duration of atrial fibrillation is also required. Attention to withdrawal of chronic anticoagulation and attendant risks of surgical bleeding is also required.

Description of Intra-Service Work: Under general anesthesia and through median sternotomy on the beating, working heart, a series of atrial lesions were created using an ablative energy source to isolate or redirect abnormal atrial depolarization site(s). An extensive lesion set was made, involving both atria or creating conduction block involving the AV annulus. Special attention is paid to ablative energy delivery to avoid injury to coronary arteries or the esophagus. The left atrial appendage is excised. Temporary atrial and ventricular pacing wires are placed.

Description of Post-Service Work: Additional postoperative visits are typically required due to the paradoxically increased incidence of atrial flutter/fibrillation related to the add-on procedure and the need for prompt conversion to sinus rhythm to mitigate against persistence of atrial fibrillation. Antiarrhythmic drugs are typically required, and oral anticoagulation frequently needed. These aspects result in increased discharge management work and additional office visits

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Kirk Kanter, MD					
Specialty(s):	Society of Thoracic Surgeons					
CPT Code:	33258					
Sample Size:	300	**Resp N:** 70	**Response:** 23.3 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**2.00**	6.00	25.00

CPT Code: 33258

Survey RVW:		2.54	5.88	**10.00**	11.00	20.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	30.00	**45.00**	60.00	300.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	140.0	99291x **2.0** 99292x **0.0**				
Other Hospital time/visit(s):	40.0	99231x **0.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	46.0	99211x **0.0** 12x **0.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 33258	
	Specialty Recommended
Physician Work RVU:	**11.00**
Pre-Service Evaluation Time:	**15.0**
Pre-Service Positioning Time:	**0.0**
Pre-Service Scrub, Dress, Wait Time:	**0.0**
Intra-Service Time:	**45.00**

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**54.6**	99291x **0.78** 99292x **0.0**
Other Hospital time/visit(s):	**18.7**	99231x **0.0** 99232x **0.0** 99233x **0.34**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33519	ZZZ	10.49	**RUC Time**

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**	

CPT Descriptor 1 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22842	ZZZ	12.56	**RUC Time**	

CPT Descriptor 2 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments

Other Reference CPT Code	Global	Work RVU	Time Source
33521	ZZZ	12.59	RUC Time

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (List separately in addition to code for arterial graft)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 18.5 %

TIME ESTIMATES (Median)

	CPT Code: 33258	Key Reference CPT Code: 33519	Source of Time RUC Time
Median Pre-Service Time	15.00	0.00	
Median Intra-Service Time	45.00	70.00	
Median Immediate Post-service Time	15.00	0.00	
Median Critical Care Time	54.6	28.00	
Median Other Hospital Visit Time	18.7	44.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**190.30**	**142.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.39	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.60
Urgency of medical decision making	2.88	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.02
Physical effort required	3.81	3.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.97	4.03

Outcome depends on the skill and judgment of physician	4.13	4.16
Estimated risk of malpractice suit with poor outcome	3.58	3.95

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	3.37
Intra-Service intensity/complexity	4.01	3.90
Post-Service intensity/complexity	3.36	3.28

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Additional Rationale:

The STS is recommending the 75th percentile value for 33258, rather than the median value which if used would result in insufficient intraservice intensity (IWPUT) or insufficient pre- and post service elements recommended by the survey respondents. It is clear, from reviewing the survey results, that the respondents allocated substantial additional pre- and post-service work elements, but failed to consider them in estimating the overall code value. In fact, 83% of the respondents assigned more work to pre- and post-services than they did to the total code work value.

Using the median responses for total RVW, intraservice time, and additional pre- and post-service time and visits results in an IWPUT of -0.108, in that the recommended pre- and post service work exceeds the total median survey RVW. Using the 75th percentile RVW, while retaining the same pre- and post-values, still results in an IWPUT of -0.086.

It is also clear from the survey results that, despite the instructions, many respondents did not understand that ZZZ pre- and post-service time and work should be additional to that already present in the base procedure. Accordingly, STS queried its National Cardiac Database for procedures in 2004, 2005 and 2006 where this procedure was performed as the sole additional procedure, in combination with any of 35 base procedural code or code combinations. 235 such procedures were identified, and compared to weighted average data from 356,560 patients having matching base procedures alone. The results are illustrated in the following table:

	Base Procedures	33258 Extensive Maze no CPB	Absolute Delta	Relative Delta
Number of Patients		235		
Age(Years)	65.3	72.3	7.0	11%
Age >= 65	54.4%	84.7%	30.3%	56%
Gender (Male)	69.4%	72.5%	3.1%	4%
Weight(kg)	85.9	86.0	0.1	0%

Diabetes	35.7%	31.4%	-4.3%	-12%
PVD	15.1%	20.3%	5.2%	35%
CVD	13.7%	19.9%	6.2%	45%
Previous CV Intervention	24.5%	25.4%	0.9%	4%
Previous PCI	73.6%	59.8%	-13.9%	-19%
Congestive Heart Failure	14.4%	27.5%	13.2%	92%
Cardiogenic Shock	1.8%	0.4%	-1.4%	-77%
Ejection Fraction	51.0	48.9	-2.1	-4%
Intraop Blood Products	34.7%	29.4%	-5.3%	-15%
Postop Blood Products	39.4%	48.7%	9.2%	23%
Total Hours Ventilated	15.7	22.7	7.0	45%
Total ICU Hours	53.8	72.7	18.8	35%
Post Operative LOS	6.3	7.5	1.1	18%
Mortality	1.7%	3.5%	1.8%	106%
Readmisson <=30 Days	9.2%	11.9%	2.7%	29%

These data unequivocally demonstrate that the use of 33258 identifies a population of patients that are significantly older and sicker than those not undergoing 33258 or any other concomitant procedure. The 92% increase in preoperative heart failure and 45% increase in cerebrovascular disease are consistent with the presence of atrial fibrillation and more advanced age (7.0 years per patient). These patient characteristics and the impact of 33258 performance result in 18.8 additional ICU hours per patient, and an additional 1.1 days of hospital stay. The patients are more to be readmitted to the hospital, and are less likely to survive.

These data confirm in the survey results regarding pre- and post-service additional work, and STS recommends using the method approved in the 2005 5-year review to allocate post-service in-hospital E&M fractional visits from these data. It should be stressed that the add-on maze patient data were not included in the 5 year review where multiple procedure patients were appropriately excluded from the analysis. Therefore, the additional resulting physician work is not included in the base procedure code values.

We also recommend reductions in the survey recommended pre-service time and outpatient office visits. The latter single additional visit is consistent with the known need to manage anti-arrhythmic agents, arrhythmias, and anticoagulation and is consistent with the 29% increase in hospital readmission rate. We recommend reduction of the recommended 99238 by 50%, which in effect will provide the patient with a 99239 discharge day when combined with the base code. This is consistent with the increased work associated with drug and drug interaction management and arrhythmia counseling and discharge planning.

Using these recommendations, with the 75th percentile survey RVW results in an IWPUT of 0.094, which is well within the range of previously approved IWPUT for cardiac surgery codes. We note that this value represents 38% of the stand alone 090 global version of the ZZZ code, less than the 50% reduction that would otherwise apply.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. Utilization Table for 33258 from STS database data
4. CPT code description CPT Code X1 Extensive Maze No CPB
5. Coronary artery bypass, using arterial and venous grafts 33533-6 33517-23 192 85.3%
6. Coronary artery bypass, using arterial graft(s) 33533-33536 33533 16 7.1%
7. Coronary artery bypass, vein only; two coronary venous grafts 33511 7 3.1%
8. Coronary artery bypass, vein only; three coronary venous grafts 33512 5 2.2%
9. Coronary artery bypass, vein only; four coronary venous grafts 33513 3 1.3%
10. Coronary artery bypass, vein only; single coronary venous graft 33510 1 0.4%
11. Coronary artery bypass, vein only; five coronary venous grafts 33514 1 0.4%
12.
13. Total 2.5 Years STS database 225 100.0%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33253

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 225
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Based on STS database date over a 2.5 year period

Specialty cardiothoracic surgery Frequency 225 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
123. If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. The STS database mean age is over 65 so it is estimated that approximately 55% of these procedures are performed in the Medicare population.

Specialty cardiothoracic surgery Frequency 123 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 33519 Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33259 Tracking Number EE3 Specialty Society Recommended RVU: **14.14**
Global Period: ZZZ RUC Recommended RVU: **14.14**

CPT Descriptor: Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman presents with progressive heart failure, severe mitral regurgitation and a 5 year history of atrial fibrillation requiring anticoagulation. An echocardiogram shows biventricular and biatrial enlargement. At the time of her cardiac procedure, an extensive operative tissue ablation and reconstruction of atria (eg, maze procedure) is performed with cardiopulmonary bypass.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Additional physician work includes review of the echocardiogram report with attention to left atrial size to determine that a formal, extensive maze procedure is appropriate. Careful review of the patients arrhythmia history, including documentation of the duration of atrial fibrillation is also required. Attention to withdrawal of chronic anticoagulation and attendant risks of surgical bleeding is also required.

Description of Intra-Service Work: Under general anesthesia and on cardiopulmonary bypass, a series of atrial lesions were created using surgical incision and/or an ablative energy source to isolate or redirect abnormal atrial depolarization site(s). An extensive lesion set was made, involving both atria or creating conduction block involving the AV annulus. Special attention is paid to ablative energy delivery to avoid injury to coronary arteries or the esophagus. The left atrial appendage is excised. Temporary atrial and ventricular pacing wires are placed.

Description of Post-Service Work: Additional postoperative visits are typically required due to the paradoxically increased incidence of atrial flutter/fibrillation related to the add-on procedure and the need for prompt conversion to sinus rhythm to mitigate against persistence of atrial fibrillation. Antiarrhythmic drugs are typically required, and oral anticoagulation frequently needed. These aspects result in increased discharge management work and additional office visits

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Kirk Kanter, MD					
Specialty(s):	Society of Thoracic Surgeons					
CPT Code:	33259					
Sample Size:	300	**Resp N:**	70	**Response:** 23.3 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	6.00	**10.00**	20.00	60.00

CPT Code: 33259

Survey RVW:		3.60	7.83	**11.00**	14.14	20.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		15.00	40.00	**48.00**	73.00	360.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	140.0	99291x **2.0** 99292x **0.0**				
Other Hospital time/visit(s):	80.0	99231x **0.0** 99232x **2.0** 99233x **0.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	46.0	99211x **0.0** 12x **0.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 33259	
	Specialty Recommended
Physician Work RVU:	14.14
Pre-Service Evaluation Time:	15.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	48.00

Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	46.2	99291x 0.66 99292x 0.0
Other Hospital time/visit(s):	33.5	99231x 0.0 99232x 0.0 99233x 0.61
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	46.0	99211x 0.0 12x 0.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33519	ZZZ	10.49	RUC Time

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22840	ZZZ	12.52	RUC Time	

CPT Descriptor 1 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22842	ZZZ	12.56	RUC Time	

CPT Descriptor 2 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments

Other Reference CPT Code	Global	Work RVU	Time Source
33522	ZZZ	14.14	RUC Time

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 27.1 %

TIME ESTIMATES (Median)

	CPT Code: 33259	Key Reference CPT Code: 33519	Source of Time RUC Time
Median Pre-Service Time	15.00	0.00	
Median Intra-Service Time	48.00	70.00	
Median Immediate Post-service Time	15.00	0.00	
Median Critical Care Time	46.2	28.00	
Median Other Hospital Visit Time	33.5	44.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	46.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**222.70**	**142.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.95	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.84
Urgency of medical decision making	3.26	3.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.26	4.26
Physical effort required	4.26	4.16

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.42	4.26

Outcome depends on the skill and judgment of physician	4.58	4.58
Estimated risk of malpractice suit with poor outcome	4.16	4.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	3.61
Intra-Service intensity/complexity	4.32	4.22
Post-Service intensity/complexity	3.79	3.72

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Additional Rationale:

The STS is recommending the 75th percentile value for 33259, rather than the median value which if used would result in insufficient intraservice intensity (IWPUT) or insufficient pre- and post service elements recommended by the survey respondents. It is clear, from reviewing the survey results, that the respondents allocated substantial additional pre- and post-service work elements, but failed to consider them in estimating the overall code value. In fact, 83% of the respondents assigned more work to pre- and post-services than they did to the total code work value.

Using the median responses for total RVW, intraservice time, and additional pre- and post-service time and visits results in an IWPUT of -0.136, in that the recommended pre- and post service work exceeds the total median survey RVW. Using the 75th percentile RVW, while retaining the same pre- and post-values, still results in an IWPUT of -0.070.

It is also clear from the survey results that, despite the instructions, many respondents did not understand that ZZZ pre- and post-service time and work should be additional to that already present in the base procedure. Accordingly, STS queried its National Cardiac Database for procedures in 2004, 2005 and 2006 where this procedure was performed as the sole additional procedure, in combination with any of 55 base procedural code or code combinations. 3,770 such procedures were identified, and compared to weighted average data from 356,560 patients having matching base procedures alone. The results are illustrated in the following table:

Cohort		Base Procedures	33259 Extensive Maze on CPB	Absolute Delta	Relative Delta
Number of Patients			3,770		
Age(Years)	Mean	62.1	67.3	5.2	8%
Age >= 65	%Yes	45.8%	64.3%	18.5%	40%
Gender (Male)	%Yes	60.2%	62.1%	2.0%	3%
Weight(kg)	Mean	82.6	84.6	2.0	2%
Diabetes	%Yes	22.7%	23.0%	0.3%	2%

PVD	%Yes	8.8%	9.6%	0.8%	9%
CVD	%Yes	10.9%	14.8%	3.9%	36%
Previous CV Intervention	%Yes	16.2%	18.7%	2.4%	15%
Previous PCI	%Yes	49.7%	50.6%	1.0%	2%
Congestive Heart Failure	%Yes	28.1%	35.2%	7.2%	25%
Cardiogenic Shock	%Yes	1.5%	0.7%	-0.7%	-51%
Ejection Fraction	Mean	53.7	51.3	-2.4	-4%
Intraop Blood Products	%Yes	36.7%	39.4%	2.7%	7%
Postop Blood Products	%Yes	38.5%	45.8%	7.3%	19%
Total Hours Ventilated	Mean	16.7	21.9	5.2	31%
Total ICU Hours	Mean	57.3	73.3	16.0	28%
Post Operative LOS	Mean	6.9	8.2	1.3	19%
Mortality	%Yes	2.1%	3.0%	0.9%	43%
Readmisson <=30 Days	%Yes	10.1%	11.5%	1.4%	14%

These data unequivocally demonstrate that the use of 33259 identifies a population of patients that are significantly older and sicker than those not undergoing 33259 or any other concomitant procedure. The 25% increase in preoperative heart failure and 36% increase in cerebrovascular disease are consistent with the presence of atrial fibrillation and more advanced age (5.2 years per patient). These patient characteristics and the impact of 33258 performance result in 16 additional ICU hours per patient, and an additional 1.3 days of hospital stay. The patients are more to be readmitted to the hospital, and are less likely to survive.

These data confirm in the survey results regarding pre- and post-service additional work, and STS recommends using the method approved in the 2005 5-year review to allocate post-service in-hospital E&M fractional visits from these data. It should be stressed that the add-on maze patient data were not included in the 5 year review where multiple procedure patients were appropriately excluded from the analysis. Therefore, the additional resulting physician work is not included in the base procedure code values.

We recommend retaining the two additional office visits as consistent with the known need to manage anti-arrhythmic agents, arrhythmias, and anticoagulation, consistent with the use of cardiopulmonary bypass, a 35.2% incidence of CHF and a 14% increase in hospital readmission rate. We recommend reduction of the recommended 99238 by 50%, which in effect will provide the patient with a 99239 discharge day when combined with the base code. This is consistent with the increased work associated with drug and drug interaction management and arrhythmia counseling and discharge planning.

Using these recommendations, with the 75th percentile survey RVW results in an IWPUT of 0.129, which is within the range of previously approved IWPUT for cardiac surgery codes. We note that this value represents 41% of the stand alone 090 global version of the ZZZ code, less than the 50% reduction that would otherwise apply.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3. Utilization table for 33259 from STS database data CPT code description
4. CPT Code X2 Extensive Maze CPB
5. Coronary artery bypass, using arterial and venous grafts 33533-6 33517-23 1345 36.9%
6. Replacement, mitral valve, with cardiopulmonary bypass 33430 750 20.6%
7. Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction 33427 557 15.3%
8. Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve 33405 439 12.0%
9. Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring 33426 265 7.3%
10. Repair atrial septal defect, secundum with or without patch 33641 48 1.3%
11. Coronary artery bypass, using arterial graft(s) 33533-33536 33533 43 1.2%
12. Replacement, aortic valve with stentless tissue valve 33410 30 0.8%
13. Coronary artery bypass, vein only; three coronary venous grafts 33512 29 0.8%
14. Coronary artery bypass, vein only; two coronary venous grafts 33511 17 0.5%
15. Coronary artery bypass, vein only; four coronary venous grafts 33513 17 0.5%
16. Valvuloplasty, mitral valve, with cardiopulmonary bypass; 33425 15 0.4%
17. Valvuloplasty, tricuspid valve; with ring insertion 33464 15 0.4%
18. Valvuloplasty, tricuspid valve; with ring insertion 33464 15 0.4%
19. Coronary artery bypass, vein only; single coronary venous graft 33510 10 0.3%
20. Valvuloplasty, aortic valve; open, with cardiopulmonary bypass 33400 9 0.2%
21. Replacement, tricuspid valve, with cardiopulmonary bypass 33465 9 0.2%
22. Ascending aorta graft,with aortic root replacement and coronary reconstruction 33863 8 0.2%
23. Coronary artery bypass, vein only; five coronary venous grafts 33514 5 0.1%
24. Coronary artery bypass, vein only; six or more coronary venous grafts 33516 4 0.1%
25. Repair of postinfarction ventricular septal defect 33545 3 0.1%
26. Replacement aortic valve with allograft valve (freehand) 33406 2 0.1%
27. Transverse arch graft, with cardiopulmonary bypass 33870 2 0.1%
28. Descending thoracic aorta graft, with or without bypass 33875 2 0.1%
29. Transverse arch graft, with cardiopulmonary bypass 33870 2 0.1%
30. Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis 33415 1 0.0%
31. Myocardial resection (eg, ventricular aneurysmectomy) 33542 1 0.0%
32. SVR or Dor Procedure (New Code) 3354X 1 0.0%
33.
34. Total 2.5 Years STS database 3644 100.0%
35.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33253

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3644
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Based on STS database data for a 2.5 year period

Specialty cardiothoracic surgery Frequency 2004 Percentage 54.99 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2004 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The STS database mean age is over 65 so it is estimated that approximately 55% of these procedures are performed in the Medicare population

Specialty cardiothoracic surgery Frequency 3644 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 33522 Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft) provides the most accurate crosswalk for this procedure.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
090 Day Global Period
Facility-ONLY Direct Inputs

CPT	DESCRIPTION	GLOBAL
33257 EE1	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to code for primary procedure)	ZZZ
33258 EE2	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	ZZZ
33259 EE3	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition to code for primary procedure)	ZZZ

CLINICAL STAFF TIME:

Pre-service period clinical staff time: Sixty minutes has been established by a PEAC workgroup as the typical total time it takes on average across all specialties and for all categories of pre-service work to get a patient into a facility for a procedure. This time has been applied at an RN staff level which was approved by the PEAC for cardiothoracic surgery procedures.

Service period clinical staff time: The assignment of 6 minutes (12 minutes is supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied. 6 minutes was applied because the procedures only contain a ½ discharge day.

Post-service period clinical staff time: Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:

Standard PEAC minimum multispecialty office visit supplies and incision care have been applied.

	A	B	C	D	E	F
1				EE1	EE2	EE3
2				33257	33258	33259
3	Meeting Date: 4/2007			Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to code for primary	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in	Operative tissue ablation and reconstruction of atria, performed at th time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition
4	LOCATION	CMS Code	Staff Type	Facility	Facility	Facility
5	GLOBAL PERIOD			ZZZ	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			102.0	102.0	138.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			60.0	60.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			6.0	6.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			36.0	36.0	72.0
10						
11	**Start: Following visit when decision for surgery or procedure made**					
12	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5
13	Coordinate pre-surgery services	L051A	RN	20	20	20
14	Schedule space and equipment in facility	L051A	RN	8	8	8
15	Provide pre-service education/obtain consent	L051A	RN	20	20	20
16	Follow-up phone calls & prescriptions	L051A	RN	7	7	7
17	Other Clinical Activity (please specify)	L051A	RN			
18	**End:When patient enters office/facility for surgery/procedure**					
19						
20	**Start: When patient enters office/facility for surgery/procedure**					
21	**Pre-service services**					
22	Review charts					
23	Greet patient and provide gowning					
24	Obtain vital signs					
25	Provide pre-service education/obtain consent					
26	Prepare room, equipment, supplies					
27	Setup scope (non facility setting only)					
28	Prepare and position patient/ monitor patient/ set up IV					
29	Sedate/apply anesthesia					
30	**Intra-service**					
31	Assist physician in performing procedure					
32	**Post-Service**					
33	Monitor pt. following service/check tubes, monitors, drains	1				
34	Clean room/equipment by physician staff					
35	Clean Scope					
36	Clean Surgical Instrument Package					
37	Complete diagnostic forms, lab & X-ray requisitions					
38	Review/read X-ray, lab, and pathology reports					
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
40	Discharge day management 99238 –12 minutes 99239 –15 minutes	L051A	RN	6	6	6
41	Other Clinical Activity (please specify)					
42	**End: Patient leaves office**					
43						
44	**Start: Patient leaves office/facility**					
45	Conduct phone calls/call in prescriptions					
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care					
47	*List Number and Level of Office Visits*					
48	99211 16 minutes		16			
49	99212 27 minutes		27			
50	99213 36 minutes		36	1	1	2
51	99214 53 minutes		53			
52	99215 63 minutes		63			
53	Other					
54						
55	*Total Office Visit Time*			36	36	72
56	Other Activity (please specify)					
57	**End: with last office visit before end of global period**					

	A	B	C	D	E	F
2				33257	33258	33259
3	Meeting Date: 4/2007			Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to code for primary	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition
4	LOCATION	CMS Code	Staff Type	Facility	Facility	Facility
58						
59	pack, minimum multi-specialty visit	SA048	pack	1	1	1
60	pack, post-op incision care (suture & staple)	SA053	pack	1	1	1
61						
62						
63						
64						
65						
66						
67	table, power	EF031		53	53	106
68	light, exam	EQ168		53	53	106
69						

TAB 23 Multiple Procedure Sheet

Combined Procedures

CPT Code	Global	IWPUT	work RVU	Pre eval	Pre Posit	Pre SDW	Intra Time	Post time	91	92	31	32	33	38	39	15	14	13	12	11
				0.0224	0.0224	0.0081		0.0224	4.50	2.25	2.00	1.39	0.76	1.28	1.90	2.00	1.42	0.92	0.45	0.17
									70	30	55	40	20	38	55	55	40	23	16	7
33533	90	0.89	33.64	60	15	20	151	40	1		1	2	3	1			1		1	
3325X0	ZZZ	0.11	9.63	15			30	15	0.64				0.61	0.5				1		
Totals		0.112	**43.27**	**75**	**15**	**20**	**181**	**55**	**1.64**		**1**	**2**	**3.61**		**1**	**0**	**1**	**1**	**1**	

CPT Code	Global	IWPUT	work RVU	Pre time eval	Pre time Posit	Pre time SDW	Intra Time	Post time	91	92	31	32	33	38	39	15	14	13	12	11
33533	90	0.89	33.64	60	15	20	151	40	1		1	2	3	1			1		1	
3325X1	ZZZ	0.102	11	15			45	30	0.78				0.34	0.5				1		
Totals		0.107	**44.64**	**75**	**15**	**20**	**196**	**70**	**1.78**	**0**	**1**	**2**	**3.3**		**1**	**0**	**1**	**1**	**1**	

CPT Code	Global	IWPUT	work RVU	Pre time eval	Pre time Posit	Pre time SDW	Intra Time	Post time	91	92	31	32	33	38	39	15	14	13	12	11
33533	90	0.89	33.64	60	15	20	151	40	1		1	2	3	1			1		1	
3325X2	ZZZ	0.142	14.14	15			48	15	0.66				0.61	0.5				2		
Totals		0.119	**47.78**	**75**	**15**	**20**	**199**	**55**	**1.66**	**0**	**1**	**2**	**3.6**		**1**	**0**	**1**	**2**	**1**	

Reference

CPT Code	Global	IWPUT	work RVU	Pre time eval	Pre time Posit	Pre time SDW	Intra Time	Post time	91	92	31	32	33	38	39	15	14	13	12	11
33548	90	0.128	53.96	60	15	20	217	40	2	1	1	2	3		1		1	2		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Valve Sparing Aortic Annulus Reconstruction

The CPT Editorial Panel created a new CPT code to report performance of root reconstruction in which the aortic valve is preserved and the aortic annulus is remodeled. The current codes represent different work from that involved in a valve sparing aortic annulus reconstruction. Changes in the patient population as well as changes in technology and techniques have allowed surgeons to perform a root reconstruction preserving the aortic valve and remodeling the aortic annulus, when indicated in a certain population of patients.

The RUC reviewed CPT code 33864 *Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)* in comparison to its reference code, 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (Work RVU=58.71). The RUC noted that the intra-service time associated with the surveyed code is greater than the intra-service time associated with the reference code, 300 minutes and 287 minutes, respectively. Additionally, the RUC compared the intensity/complexity measures of the surveyed code to the reference code and noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, because the surveyed code has more intra-service time and greater intensity/complexity than the reference code, the RUC recommends the median survey value, 60.00 RVUs. **The RUC recommends 60.00 RVUs for 33864.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense inputs package for 33864.

New Technology:
The RUC recommends that 33864 be added to the new technology list as this procedure utilizes new techniques.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
33861	FF1	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction	090	43.94 (No Change)
33863	FF2	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction	090	58.71 (No Change)
●33864	FF3	Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure) (Do not report 33864 in conjunction with 32020, 33210-33211, 33400, 33860, 33861, 33863)	090	60.00

1032

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33864 Tracking Number FF3 Specialty Society Recommended RVU: **60.00**
Global Period: 090 RUC Recommended RVU: **60.00**

CPT Descriptor: Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old male with Marfan's syndrome is followed with serial echocardiograms looking for increasing aortic root dimensions. Echocardiogram shows a 5.5 cm ascending aorta with aortic annulus dilatation with mild aortic insufficiency. He is referred for a valve sparing root reconstruction.

Percentage of Survey Respondents who found Vignette to be Typical: 64%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for peri-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews incision and procedure, talks with pateint and family and answers any questions, obtains informed consent, confirms O.R. start time, changes into scrubs, reviews with anesthesia, dresses, waits, places bladder catheter, postitions and pads patient, scrubs, gloves, preps and drapes patient.

Description of Intra-Service Work: Performs standard median sternotomy skin incision, divides the sternum in the midline with a saw, places aortic and venous cannulas, assesses ascending aorta. Determines level of heparinization, establishes cardiopulmonary bypass, initiates systemic cooling, places antegrade and retrograde cardiplegia cannulas, adminsters cardioplegia, assesses heart for distention, cooling and cardioplegic arrest, opens ascending aorta, and evaluates aortic root and aortic valve.

The aortic valve and annulus are assessed and sized. The proximal aortic root is excised mobilizing the coronary artery ostia with cuffs of aortic tissue and leaving the native aortic valve and commissures intact. Multiple interrupted pledgetted sutures are placed beneath the aortic valve from the left ventricle to the base of the aortic root. These are passed through the proximal portion of a suitably sized Dacron graft. The graft is seated down and the sutures tied, thus fixing/remodelling the aortic annulus. The aortic valve and commissures are reattached at the appropriate height to the inside of the Dacron graft resuspending the valve using continuous sutures. Oval defects are created in the sinuses of the Dacron graft and the coronary buttons are reimplanted into the Dacron graft. The distal portion of the Dacron graft is now sewn to the normal distal ascending aorta evacuating air from the left side of the heart before tying down the last stitch.

The patient is placed in Trendelenberg, evacuate air, remove cross-clamp, vent aortic root until LV ejection present for 5-10 minutes, evaluate air in left side of heart and degree of aortic valve insuffuciency using transesophageal echocardiogram, resuscitate the heart by allowing it to beat while unloaded on cardiopulmonary bypass, ensure hemostasis, place temporary pacing wires and begin pacing if necessary, discontinue cardiopulmonary bypass, remove cannulas and close sites, place drains, re-approximate sternum and close chest.

Description of Post-Service Work: Apply sterile dressings to the incisions, remove drapes, transfer pateint to ICU, follow patient through day in ICU and provide critical care as necessary, talk to family, talk to and coordinate care with other physicians, write orders, write op note, discuss outcome with patient and family, evaluate patient post ICU, follow

patient daily while in hospital, discharge patient from hospital, follow-up with patient as necessary once discharged from hospital.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Kirk Kanter, MD				
Specialty(s):	Society of Thoracic Surgeons				
CPT Code:	33864				
Sample Size: 200	**Resp N:** 28	**Response:** 14.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**4.00**	5.00	20.00
Survey RVW:	52.00	59.65	**60.00**	64.25	80.00
Pre-Service Evaluation Time:			**85.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**20.0**		
Intra-Service Time:	150.00	240.00	**300.00**	300.00	360.00
Immediate Post Service-Time:	**60.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**140.0**	99291x **2.0** 99292x **0.0**			
Other Hospital time/visit(s):	**155.0**	99231x **1.0** 99232x **2.0** 99233x **1.0**			
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**			
Office time/visit(s):	**40.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **1.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 33864		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		
Pre-Service Positioning Time:		
Pre-Service Scrub, Dress, Wait Time:		
Intra-Service Time:		
Immediate Post Service-Time:	____	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 99292x
Other Hospital time/visit(s):	0.0	99231x 99232x 99233x
Discharge Day Mgmt:	0.0	99238x 99239x
Office time/visit(s):	0.0	99211x 12x 13x 14x 15x
Prolonged Services:	0.0	99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33863	090	58.71	RUC Time

CPT Descriptor Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
61697	090	63.22	RUC Time	

CPT Descriptor 1 Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
41730	090	57.06	RUC Time	

CPT Descriptor 2 Hepatectomy, resection of liver; total right lobectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 78.2 %

TIME ESTIMATES (Median)

	CPT Code: 33864	Key Reference CPT Code: 33863	Source of Time RUC Time
Median Pre-Service Time	~~115.00~~ 120	95	
Median Intra-Service Time	300.00	287.00	
Median Immediate Post-service Time	60.00	40.00	
Median Critical Care Time	140.0	140.00	
Median Other Hospital Visit Time	155.0	265.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	40.0	40.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	~~848.00~~ 853	**905.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.47	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	4.00
Urgency of medical decision making	3.74	3.61

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	4.36
Physical effort required	4.68	4.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.79	4.50
Outcome depends on the skill and judgment of physician	4.84	4.56

Estimated risk of malpractice suit with poor outcome	4.21	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.32	3.89
Intra-Service intensity/complexity	4.89	4.50
Post-Service intensity/complexity	3.95	3.78

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33861 or 33863

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 150
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Marfan's syndrome affects 1 in 5,000 people in the US; most people with Marfan's have some aortic root dilatation and Aortic root dilation with annuloaortic ectasia without Marfan's Syndrome affects in 1 in 10,000 people in the US. As currently reported - Approximately 5% of 33863 (90)
Approximately 10% of 33861 (26)

Specialty cardiothoracic surgery Frequency 150 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This procedure is predominatley preformed in non-medicare patients.

Specialty cardiothoracic surgery Frequency 5 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
090 Day Global Period
Facility-ONLY Direct Inputs

CPT	DESCRIPTION	GLOBAL
33864	**Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)**	090

CLINICAL STAFF TIME:

Pre-service period clinical staff time: Sixty minutes has been established by a PEAC workgroup as the typical total time it takes on average across all specialties and for all categories of pre-service work to get a patient into a facility for a procedure. This time has been applied at an RN staff level which was approved by the PEAC for cardiothoracic surgery procedures.

Service period clinical staff time: The assignment of 12 minutes (as supported by the PEAC) relative to coding of 99238 for discharge management for inpatient services has been applied.

Post-service period clinical staff time: Standard EM postop OFFICE visit times for clinical staff have been applied as appropriate.

SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:

Standard PEAC minimum multispecialty office visit supplies and incision care supplies have been applied. Standard power table and light exam have been applied

	A	B	C	D	E
1				33864	
2	Meeting Date: 04/2007			Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)	
3	LOCATION	CMS Code	Staff Type	Facility	
4	GLOBAL PERIOD 90				
5	TOTAL CLINICAL LABOR TIME	L051A	RN	125.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	60.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	12.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	53.0	
9	[illegible]				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L051A	RN	5	
12	Coordinate pre-surgery services	L051A	RN	20	
13	Schedule space and equipment in facility	L051A	RN	8	
14	Provide pre-service education/obtain consent	L051A	RN	20	
15	Follow-up phone calls & prescriptions	L051A	RN	7	
16	Other Clinical Activity (please specify)				
17	End:When patient enters office/facility for surgery/procedure				
18	[illegible]				
19	Start: When patient enters office/facility for surgery/procedure				
20	Pre-service services				
21	Review charts				
22	Greet patient and provide gowning				
23	Obtain vital signs				
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies				
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV				
28	Sedate/apply anesthesia				
29	Intra-service				
30	Assist physician in performing procedure				
31	Post-Service				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff				
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Discharge day management 99238 --12 minutes	L051A	RN	12	
40	Other Clinical Activity (please specify)				
41	End: Patient leaves office				
42	[illegible]				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions				
45	*Office visits:*				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes		36		
50	99214 53 minutes		53	1	
51	99215 63 minutes		63		
52	Other				
53	*Total Office Visit Time*			53	
54	Other Activity (please specify)				
55	End: with last office visit before end of global period				
56	[illegible]	[illegible]	[illegible]	[illegible]	
57	pack, minimum multi-specialty visit	SA048	pack	1	
58	pack, post-op incision care (suture & staple)	SA053	pack	1	
59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60	table, power	EF031		53	
61	light, exam	EQ168		53	
62					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Wireless Pressure Sensor Implantation

The CPT Editorial Panel replaced two Category III codes with two new Category I codes to describe the placement and subsequent monitoring of an implanted wireless pressure sensor located inside the body, within an aneurysm sac, but outside an endovascular graft as the service is currently performed 1,000 times per year and is likely to increase in utilization rapidly.

34806

The RUC reviewed the survey data for code 34806 *Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data.* The RUC compared 34806 to the key reference code indicated by the survey respondents, 34808 *Endovascular placement of iliac artery occlusion device* (Work RVU=4.12). The specialty societies indicated and the RUC agreed that the key reference service requires two times more physician work than 34806. The reference service has a total physician time of 60 minutes, however the new service requires a total of 35 minutes to complete (10 minutes pre-service time and 25 minutes intra-service time). The add-on reference service has zero pre- and post-time, however, the new service requires 10 minutes of pre-service evaluation time because sensor implantation is an independent and separate service that requires discussion with the patient and family during final preparations on the date of surgery as the physician reviews issues surrounding informed consent. Additionally, the surgeon/intervetionalist needs to ensure that the appropriate devices are present in the operating room and that the "Interrogator" (instrument that excites the sensor and records data from implanted device) is present and available. The RUC agreed that pre-service time of 10 minutes, intra-service time of 25 minutes is appropriate for code 34806.

The RUC recommends a work RVU of 2.06 for code 34806.

93982

The RUC discussed CPT code 93982 *Non-invasive physiologic study of implanted wireless pressure sensor in aneurismal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report*, and clarified that the service would have both a professional component (PC) and technical component (TC). The RUC then reviewed the specialty society survey results regarding physician work involved in the service. The RUC agreed with the specialty society recommendations to reduce the pre- and post-service times to two minutes each, because based on the associated work the pre- and post-service time is minimal. Further, the RUC agreed with the specialty society and determined that the 25th percentile survey work RVU, 0.30, was appropriate and maintained proper rank order in relation to the key reference service, CPT code 93731 *Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable*

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parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming, (Work RVU = 0.45). Additionally, the reference service has slightly higher pre-, intra-, and post-service times (pre = 5 minutes, intra = 15 minutes, post = 5 minutes) and nearly identical intensity/complexity measures. The RUC agreed that pre-service time of 2 minutes, intra-service time of 10 minutes, and post-service time of 2 minutes is appropriate for code 93982.

The RUC recommends a work RVU of 0.30 for code 93982.

Practice Expense
34806
The RUC determined and recommends that no direct practice expense inputs are required for code 34806.

93982
The RUC discussed the practice expenses involved in the technical component of this service performed in the non-facility setting. The RUC determined that the pre-service clinical activity of retrieving and reviewing patient records and previous studies was more appropriately accounted for in the intra-service period and performed by the technologist. Therefore, the pre-service time was reduced from three minutes to zero. The RUC also noted that the study takes place in a room that does not require preparation of the room, equipment or supplies and removed the two minutes allotted. The assist physician time denoted as 15 minutes was verified by the specialty societies and the RUC agreed that the time was appropriate. The intra-service time is not specifically spent assisting the physician, but rather includes the time for the technologist to perform the test. The specialty societies also discussed the other service period time and the RUC determined that time was appropriately allotted to greet the patient, obtain vitals, obtain consent, set-up equipment, and position the patient. **The RUC recommends the direct practice expense inputs as amended for code 93982.**

New Technology
As these codes were previously reported using the Category III codes, the RUC recommends that codes 34806 and 93982 be added to the New Technology List so that these services can be closely monitored for any changes in utilization.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●+34806	GG1	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data (List in	ZZZ	2.06

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		addition to the code for the primary procedure) (Use 34806 in conjunction with 33880, 33881, 33886, 34800-34805, 34825, 34900) (Do not report 34806 in conjunction with 93982)		
Medicine **Non Invasive Vascular Diagnostic Studies** **Visceral and Penile Vascular Studies**				
●93982	GG2	Non-invasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report (Do not report 93982 in conjunction with 34806)	XXX	0.30
Category III Codes				
D 0153T		~~Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation and instrument calibration (List separately and in addition to code for primary code)~~ ~~(Use 0153T in conjunction with 34800, 34802, 34803, 34804, 34805, 34900)~~ ~~(Use 0153T includes deployment of the sensor, repositioning if required, and intraoperative calibration)~~		N/A
D 0154T		~~Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study include recording, analysis of pressure and waveform tracings, interpretation and report~~		N/A

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~(Do not report 0154T in conjunction with 0153T)~~		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:34806 Tracking Number GG1 Specialty Society Recommended RVU: **2.06**
Global Period: ZZZ RUC Recommended RVU: **2.06**

CPT Descriptor: Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data

(Report 348XX with 34800, 34802, 34803, 34804, 34805, 34825, 34900, 33880, 33881, 33886)

(Do not report 939XX with 348XX)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old male has been diagnosed with a 7.3 cm abdominal aortic aneurysm. He has elected to have the aneurysm treated using an endovascular repair. An implantable wireless pressure sensor is placed during the endovascular repair procedure.

[Note: This is an add-on code. When completing this survey, please only consider the additional work related to 348XX.]

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review CT to ensure sufficient thrombus-free space within aneurysm sac to allow safe placement of Wireless Physiologic Sensor (WPS). Discuss indications, risks and benefits of WPS with patient and family. Ensure all components present and ready in OR. Ensure device that reads sensor output is present in OR.

Description of Intra-Service Work:
- Prepare WPS introducer catheter by flushing guidewire lumen.
- Supervise technologists to position fluoroscopy unit appropriately
- Manipulate guidewire system to a position outside main body of endograft
- Advance sensor delivery system over the guidewire into correction position in the aneurysm.
- Position sensor at top of aneurysmal sac using fluoroscopic imaging.
- Use multiple projections, as required, to ensure exact placement
- Retract delivery system while maintaining position of the sensor on the tether.
- Using antenna and electronic system, calibrate sensor and take pre-exclusion measurement (measurement #1)
- Complete stent graft placement including all limbs/extensions and ballooning to achieve EVAR seal. (Note: this step is not IWPS work. It is part of endograft deployment.)
- Release sensor from tether and take post-exclusion measurement (measurement #2).
- Document final position of sensor with hard-copy imaging.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Gary Seabrook M.D., David Han, M.D., Jonathan W. Berlin, M.D., Geraldine McGinty, M.D., Bob Vogelzang, M.D.

Specialty(s):	Society for Vascular Surgery, American College of Radiology, Society of Interventional Radiology					
CPT Code:	34806					
Sample Size:	200	**Resp N:**	34	**Response:** 17.0 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**6.00**	11.00	50.00
Survey RVW:		2.00	3.99	**4.35**	4.50	12.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	20.00	**20.00**	45.00	120.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 34806	
	Specialty Recommended
Physician Work RVU:	2.06
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	25.00

Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34808	ZZZ	4.12	RUC Time

CPT Descriptor Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
13133	ZZZ	8,848	2.19	RUC Time

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
34826	ZZZ	4.12	RUC Time

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code foı primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	CPT Code: 34806	Key Reference CPT Code: 34808	Source of Time RUC Time
Median Pre-Service Time	10.00	0.00	
Median Intra-Service Time	25.00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**35.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.71
Urgency of medical decision making	2.82	2.88
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.94
Physical effort required	3.00	2.94
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.53	3.82

Outcome depends on the skill and judgment of physician	3.82	4.00
Estimated risk of malpractice suit with poor outcome	3.00	3.35

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.13
Intra-Service intensity/complexity	3.65	3.71
Post-Service intensity/complexity	2.56	2.56

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

All three specialty societies (ACR, SIR, SVS) reviewed the survey data in detail and reached the following recommendations.

PRE-TIME: There is valid pre-time for this ZZZ service. Sensor implantation is an independent and separate service that requires discussion with patient and family during final preparations on the day of surgery as the issues surrounding informed consent are reviewed. In addition, surgeon/interventionalist needs to ensure that the appropriate devices are present in OR, and that the "Interrogator" (instrument that excites the sensor and records data from the implanted device) is present and available in the OR. Median survey Pre-time for these two activities was 15 minutes. We believe 15 minutes cannot be justified, and we recommended reduction of pre-time to 10 minutes.

INTRA- and IMMEDIATE POST-TIME: There is an issue with the survey data in that all physician work involved with implantation and baseline data recording from the aneurysm sac occur in the OR before the patient's skin is closed. Therefore, all of the work is intra-work, and there is no immediate post-work. Only a minority of survey respondents entered "0" for post-service work on the RUC survey, and in fact, the median post-service survey value was 5 minutes. The RVS committees believe that survey respondents made the erroneous assumption that initial calibration and measurement of the sensor should be considered post-service work, and therefore recorded it as such on their surveys. In reality, this initial calibration and measurement takes place before the patient's skin is closed, and is therefore intra-service work based on RUC standards. To correct for this misunderstanding by survey respondents, we recommend shifting the 5 minutes of immediate post-work to intra-service work. This adjustment results in 25 minutes of intra-service work and 0 minutes of immediate post-work.

RVW: Key Reference 34808 (Endovascular placement of iliac artery occlusion device, ZZZ add-on code) was chosen by 50% of survey respondents, so it would appear to be an excellent clinical choice. The Key Reference has an RVW of 4.12, and the median survey RVW for the new service is 4.35. This appears to be a decent RVW choice, but for the fact that new service has 35 minutes total time by survey, while Key Reference has 60 minutes total time. Of course, the survey respondents are not made aware of the intra-time of the reference services, therefore, they base their responses on magnitude estimation. As noted in the intensity/complexity comparison, the new service and Key Reference have nearly identical values. This presents an unsolvable conundrum. In view of equal intensity/complexity,

but 50% less time than the Key Reference, we recommend that the RVW of new service be 50% that of the Key Reference, or 0.5 x 4.12 = 2.06.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Coding Example: Endovascular AAA repair is the primary procedure (e.g. 34802). Open femoral artery exposure (if performed) is reported separately, as is introduction of catheter in aorta. All routine radiological supervision and interpretation is reported with 75952. Payment reduction rules for multiple procedures apply (indicated by "x1/2"). Procedure is typically performed to 2 providers, the example used here is one vascular surgeon (VS) and one interventional radiologist (IR).

CPT 34802: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated device with one docking limb. VS and IR are co-surgeons for primary code, which is a 90-day global. Both report 34802-62, each is paid ½ of 1.25 x RVW, which is 23.71 VS=14.81 RVUs, IR=14.81 RVUs

CPT 34812: Open femoral artery exposure for delivery of aortic endovascular prosthesis 0-day global, RVW=6.74 x ½ (for multiple procedure rule), so VS = 3.37 RVUs

CPT 75952: Radiological S&I for endovascular AAA repair XXX 4.49 with no multiple procedure reduction, so IR=4.49

36200: Introduce catheter in aorta XXX global. RVW=3.02 x 1/2 for multiple procedure reduction =1.51 RVUs for VS and 1.51 for IR since procedure requires one catheter be placed into aorta from each exposed femoral artery.

TOTAL RVW by Specialty VS total is 19.69 RVUs and IR total is 20.81 RVUs

The RVUs for the ZZZ add-on would be superimposed on these totals.

Pre-Service Time

Pre-service time with multiple service payment reduction rules
A portion of this will be done by each of two physicians

	VS	IR
34802	68	68
34812	38	00

75952	00	20
36200	00	00
Total	106	88

The pre-time of new service, i.e. 10 minutes would be added to one of these providers, presumably the VS in this example.

Intra-Service Time

Intra-service time with multiple service payment reduction rules. A portion of this will be done by each of two physicians

	VS	IR
34802	75	75
34812	22	00
75952	00	60
36200	39	39
Total	136	174

The Intra-time of new service, i.e. 25 minutes, would be added to one of these providers.

Post-Service Time

Post-service time with multiple service payment reduction rules. A portion of this will be done by each of two physicians

	VS	IR
34802	87	87
34812	30	0
75952	15	15
36200	0	0
Total	132	102

We propose no post-time for new service, so there would be no impact on post-service time.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0153T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty SVS How often? Rarely

Specialty SVS How often? Rarely

Specialty SVS How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 30000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Used parent code 34802 to break out frequency

Specialty SVS Frequency 18000 Percentage 60.00 %

Specialty SIR Frequency 6000 Percentage 20.00 %

Specialty ACR Frequency 6000 Percentage 20.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Used freqency percentatges from parent code 34802 in order to develop an estimate.

Specialty SVS Frequency 12000 Percentage 60.00 %

Specialty SIR Frequency 4000 Percentage 20.00 %

Specialty ACR Frequency 4000 Percentage 20.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 37250

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93982 Tracking Number GG2 Specialty Society Recommended RVU: **0.30**
Global Period: XXX RUC Recommended RVU: **0.30**

CPT Descriptor: Non-invasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report

(Do not report 939XX in conjunction with 348XX)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old male underwent endovascular AAA repair with implantation of a wireless physiologic sensor one year ago. During a surveillance visit to the treating physician, sensor is used for noninvasive assessment of aneurysm pressure.

[Note: This CPT code will have a technical component (performed by a technologist) and a professional component. In responding to this survey, please consider and estimate ONLY the physician work associated with the professional component: interpretation and report writing.]

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review requisition to ensure appropriate test performed on correct patient. Review prior studies.

Description of Intra-Service Work: Review data provided by technologist including aneurysm sac waveform tracings obtained from excited implanted sensor, plus aneurysm sac pressure measurements taken from different positions of external sensor, and compare for pulsatility. Compare current waveform tracings to those obtained on all prior studies including the exam performed during surgery. Plot and compare raw pressures from aneurysm sac as well as sac pressures normalized to brachial systolic pressure. Draw conclusion based on all waveform reviews and pressure analyses regarding whether or not a clinically significant change has taken place in the physiologic status of the aneurysm sac. Dictate a report and identify those waveforms and pressure measurements that should be included in the final report.

Description of Post-Service Work: Review final report for accuracy of report transcription plus inclusion of appropriate waveforms, pressure measurements and pressure ratios

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Gary Seabrook M.D., David Han, M.D., Jonathan W. Berlin, M.D., Geraldine McGinty M.D., Bob Vogelzang, M.D.		
Specialty(s):	Society for Vascular Surgery, American College of Radiology, Society of Interventional Radiology		
CPT Code:	93982		
Sample Size:	200	**Resp N:** 31	**Response:** 15.5 %
Sample Type:	Convenience		

CPT Code: 93982

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	**6.00**	20.00	120.00
Survey RVW:		0.17	0.30	**0.50**	0.52	2.00
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	5.00	**10.00**	13.00	60.00
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 93982		
		Specialty Recommended
Physician Work RVU:		0.30
Pre-Service Evaluation Time:		2.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		10.00
Immediate Post Service-Time:	2.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93731	XXX	0.45	RUC Time

CPT Descriptor Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99212	XXX	25,000,000	0.45	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71020	XXX	16,000,000	0.22	RUC Time

CPT Descriptor 2 Radiologic examination, chest, two views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 35.4 %

TIME ESTIMATES (Median)	CPT Code: 93982	Key Reference CPT Code: 93731	Source of Time RUC Time
Median Pre-Service Time	2.00	5.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	2.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**14.00**	**25.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.73
Urgency of medical decision making	3.00	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.73	3.73
Physical effort required	2.64	2.64
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.82	2.91

Outcome depends on the skill and judgment of physician	3.64	3.64
Estimated risk of malpractice suit with poor outcome	2.91	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.55	2.55
Intra-Service intensity/complexity	3.82	3.82
Post-Service intensity/complexity	2.64	2.64

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A Multispecialty Consensus Committee (MCC) with members from ACR, SIR and SVS reviewed the survey data and determined that the pre-time of 5 minutes was difficult to justify based on the associated work, and therefore the pre-time has been reduced from the 5-minute median survey value to 2 minutes.

The MCC reviewed the survey data and determined that the post-time of 10 minutes was difficult to justify based on the associated work, and therefore the post-time has been reduced from the 10-minute median survey value to 2 minutes.

The MCC reviewed the survey intra-time and the associated work and determined that the survey median of 10 minutes is accurate and appropriate.

The recommended physician time for this service is therefore 2 minutes pre-time, 10 minutes intra-time and 2 minutes post-time for a total of 14 minutes.

The MCC compared the work of this new service, 93982 / GG2 to the most commonly cited reference service, 93731 which has an RVW of 0.45 and RUC time of 5/15/5 for a total of 25 minutes. The Committee felt that based on intensity, complexity and time comparisons, this new service 939XX must have an RVW less than the Key Reference service. Therefore, we determined the median survey RVW of 0.50 for this new service does not provide appropriate relativity.

The MCC then looked at MPC List XXX services with RVW < 0.50. CPT 71010 Chest X-ray two views has an RVW of 0.22 and a total time of 5 minutes. CPT 99212 Level 2 Established Patient Visit has an RVW of 0.45 with a total time of 16 minutes. The 25% percentile survey value for our new service is 0.30. This fits appropriately between MPC reference services 71010 and 99121.

Our MCC recommends the 25th percentile survey value of 0.30 for this service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0154T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty SVS	How often? Rarely
Specialty SIR	How often? Rarely
Specialty ACR	How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 60000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Used parent code 34802 to estimate percentages

Specialty SVS	Frequency 36000	Percentage 60.00 %
Specialty SIR	Frequency 12000	Percentage 20.00 %
Specialty ACR	Frequency 12000	Percentage 20.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 45,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approx 66% of AAA repair patients are Medicare beneficiaries, used parent code 34802 to estimate percentages.

Specialty SVS	Frequency 27000	Percentage 60.00 %
Specialty SIR	Frequency 9000	Percentage 20.00 %
Specialty ACR	Frequency 9000	Percentage 20.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: 93982 Non-invasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report

(Do not report 93982 in conjunction with 34806)

Sample Size:_____ Response Rate: (%):_____ Global Period: XXX

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology, Society for Interventional Radiology, and the Society for Vascular Surgery convened a Multispecialty Expert Consensus Panel to develop recommended direct inputs.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Retrieve previous studies for the physician to review in concert with current exam.

Intra-Service Clinical Labor Activities: Greet patient and provide gowning. Briefly explain purpose, indications and conduct of test. Reassure patient regarding noninvasive nature, no ionizing radiation, etc. Obtain verbal consent to proceed. Prepare the room and wireless pressure sensor equipment. Position the patient. Take bilateral brachial blood pressures. Position the sensor over abdomen and search for sensor output signal. Move sensor in lateral and vertical axes to optimize AAA sac sensor output signal. Record output waveforms and pressure measurements from a variety of positions based on established protocol. Help patient from stretcher and assist as needed with clothing and transport back to waiting room. Clean room and equipment.

Post-Service Clinical Labor Activities: Post-process raw output waveforms and pressure measurements into final format. Calculate sac/brachial systolic pressure ratios. Develop hardcopy package of all waveforms, pressure measurements and pressure ratios for review by the interpreting physician. Archive information, complete service sheet.

	A	B	C	D	E
1					
2				CPT Code 93982	
3	Meeting Date: April 2007 RUC AMA/Specialty Society RVS Update Committee Recommendation			Code Descriptor: Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD				
6	TOTAL CLINICAL LABOR TIME	L054A	Vascular Technologist	39.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L054A	Vascular Technologist	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L054A	Vascular Technologist	34.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L054A	Vascular Technologist	5.0	0.0
10	PRE-SERVICE				
11	Start: Following visit when decision for surgery or procedure made				
12	Other Clinical Activity: Retrieve and review previous studies	L054A			
13	End:When patient enters office/facility for surgery/procedure				
14	SERVICE PERIOD				
15	Start: When patient enters office/facility for surgery/procedure				
16	Pre-service services				
17	Review charts	L054A		2	
18	Greet patient and provide gowning	L054A		3	
19	Obtain vital signs	L054A		3	
20	Provide pre-service education/obtain consent	L054A		1	
21	Prepare room, equipment, supplies	L054A			
22	Setup wireless sensor equipment (non facility setting only)	L054A		5	
23	Prepare and position patient/ monitor patient/ set up IV	L054A		2	
24	Sedate/apply anesthesia				
25	Intra-service				
26	Technologist performs the service	L054A		15	
27	Post-Service				
28	Monitor pt. following service/check tubes, monitors, drains				
29	Clean room/equipment by physician staff	L054A		3	
30	End: Patient leaves office				
31	POST-SERVICE Period				
32	Start: Patient leaves office/facility				
33	Post-process raw output waveforms and pressure measurements into final form. Calculate sac/bracial systolic pressure ratios. Develop hardcopy package of all waveforms, pressure measurements and pressure ratios for review by interpreting physician. Archive data. Complete service sheet	L054A		5	
34					
35	*Total Office Visit Time*	L054A		5	0
36	Other Activity (please specify)				
37	End: with last office visit before end of global period				
38	MEDICAL SUPPLIES	CMS Code	Units		
39	Minimum Supply Pack / Multi Spec	SA048		1	
40	Drape, non-sterile, sheet 40in x 60 in	SB006		1	
41	Sanitizing cloth-wipe (surface, intstruments, equip)	SM022		1	
42	Paper, recording, per sheet	SK059		3	
43	Gluteraldehyde 3.4% (Cidex, Maxicide etc)	SM018		1	
44	Paper, table 7 feet	SB036	foot	7	
45	Gloves, non-sterile	SB022		2	
46					
47	Equipment	CMS Code			
48	EndoSure Interrogator EMS-5001 Price $25,000	NEED TO SUPPLY TO CMS		1	
49					
50					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Brachial-Ulnar Bypass Graft

The CPT Editorial Panel created a new code to describe upper extremity bypass grafts performed to prevent arm amputation in a patient with very advanced arterial occlusive disease and gangrene of the digits.

The RUC reviewed the survey results for code 35523 *Bypass graft, with vein; common carotid-ipsilateral internal carotid brachial-ulnar or –radial* compared to the key reference service, 35512 *Bypass graft, with vein; subclavian-brachial* (Work RVU=23.79, 68 minutes pre-service, 180 minutes intra-service and 30 minutes immediate post-service time). The specialty society indicated that this reference service is a similar procedure performed in the shoulder/upper arm region. The RUC agreed that the mental effort, technical skill and psychological stress involved when performing 35523 were comparable to 35512. The RUC determined that the survey median work RVU of 24.00 placed 35523 in the proper rank order compared to 35512. The RUC then compared the pre-, intra- and immediate post service times (75 minutes, 180 minutes and 30 minutes) for 35523 to the reference service and determined that the specialty society recommended intra-service and immediate post-service physician times were the same. The specialty society recommended pre-service time for 35523 is 7 more minutes than the reference code. The RUC determined that additional positioning time is needed to accurately position the arm and gangrenous fingertips and well as extend the shoulder without compromising neurovascular structures.

The RUC reviewed the post-operative visits and determined that code 35523 requires an additional 99212 visit than reference code 35512. The RUC determined that the additional 99212 visit is necessary because of the required attention to wound healing, patency of the bypass graft, reperfusion of the hand, return to outpatient medical balance and the care of the reperfused fingers with gangrenous fingertips. The RUC agreed that 75 minutes pre-service, 180 minutes intra-service and 30 minutes immediate post-service physician time is appropriate for 35523. The RUC recommends the following post-operative visits for code 355X2: two 99232, one 99231, one 99238, two 99212 and two 99213 visits.

The RUC recommends the survey median work RVU of 24.00 for 35523.

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Practice Expense
The RUC recommends the standard 090 day global direct practice expense inputs as attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
33501		Bypass graft, with vein; common carotid-ipsilateral internal carotid	090	19.43 (No Change)
●35523	HH1	brachial-ulnar or -radial (Do not report 35523 in conjunction with 35206, 35500, 35525, 36838) (For bypass graft with synthetic conduit, report 37799)	090	24.00
Surgery **Cardiovascular System** **Arteries** **Hemodialysis Access, Intervascular Cannulation for Extracorporeal Circulation, or Shunt Insertion**				
36838		Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome) (Do not report 36838 in conjunction with 35512, 35522, 35523, 36832, 37607, 37618)	090	21.59 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:35523 Tracking Number HH-1 Specialty Society Recommended RVU: **24.00**
Global Period: 090 RUC Recommended RVU: **24.00**

CPT Descriptor: Bypass graft, with vein; brachial-ulnar or -radial

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female smoker with a failed renal transplant presents with severe ischemic finger pain and digital gangrene on the left hand. Noninvasive studies confirm markedly diminished finger blood pressures. Arteriogram reveals occlusion of the distal brachial, proximal radial and proximal ulnar arteries with reconstitution of the radial and ulnar vessels near the wrist. She has not undergone prior hemodialysis access or other surgery in the symptomatic extremity. An arterial bypass graft using autogenous vein conduit is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive and arteriographic studies are reviewed. Informed consent is obtained from the patient following a review of surgical risks and benefits. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site. Other preoperative work includes marking the operative site, dressing, scrubbing, supervising patient positioning, moment of truth, waiting for the anesthetic to become effective, prepping, and draping the patient.

Description of Intra-Service Work:

- Proximal Dissection: Incise skin of upper arm overlying proximal brachial artery
- Dissect soft tissue to expose brachial artery, avoid injury to multiple nearby nerves & veins
- Clear soft tissue from brachial artery for 6 cm length
- Pass soft rubber loops around artery for control
- Distal Dissection: Incise skin overlying distal ulnar or radial artery, usually at the wrist
- Dissect soft tissue from around ulnar or radial artery, avoid nerve/vein injury
- Pass soft rubber loops around artery for control
- Create a tunnel from proximal to distal dissection sites in subcutaneous tissue of the forearm
- Harvest Vein Conduit: Incise skin of thigh/calf over saphenous vein
- Dissect soft tissue to identify saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from lower extremity
- Test saphenous vein conduit for leaks & repair same with 7-0 vascular suture
- Proximal Anastomosis: Anticoagulate patient with IV heparin
- Apply vascular clamps to proximal anastomosis site on brachial artery
- Perform arteriotomy
- Perform most of vein conduit to brachial artery anastomosis with fine vascular suture
- Open clamps transiently to flush system, remove air & debris

- Complete anastomosis, remove arterial clamps
- Apply additional sutures as needed to control hemorrhage
- Pass vein conduit through tunnel to ulnar or radial artery with care to avoid twists/kinks
- Distal Anastomosis: Stretch vein to full length
- Perform the ulnar or radial arteriotomy
- Cut vein conduit to match length and size of arteriotomy
- Perform most of vein conduit to ulnar or radial artery anastomosis with fine vascular suture
- Open clamps briefly to flush out air & debris
- Complete anastomosis
- Remove vascular clamps
- Apply additional sutures as required to achieve hemostasis
- Listen with Doppler and palpate distal pulses to assure bypass patency
- Irrigate all three incisions
- Achieve wound hemostasis
- Close all three incisions in multiple layers
- Recheck pulses to assure patency prior to application of sterile dressings

Description of Post-Service Work:

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria are met. The physician makes daily visits, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services including visiting nurses, meals on wheels, physical therapy, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow up for wound checks, suture/staple removal, etc. All related post-discharge care for 90-days is included in this service.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Gary Seabrook, M.D., Matthew Sideman, M.D., Robert Zwolak, M.D.					
Specialty(s):	Vascular Surgery					
CPT Code:	35523					
Sample Size:	100	**Resp N:** 33	**Response:** 33.0 %			
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	6.00	10.00
Survey RVW:		20.40	23.00	**24.00**	26.00	34.00
Pre-Service Evaluation Time:				**55.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		120.00	180.00	**180.00**	200.00	360.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**100.0**	99231x **1.0**	99232x **2.0**	99233x **0.0**		

Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 35523	
	Specialty Recommended
Physician Work RVU:	24.00
Pre-Service Evaluation Time:	45.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	20.0
Intra-Service Time:	180.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	100.0	99231x 1.0 99232x 2.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
35512	090	23.79	RUC Time

CPT Descriptor Bypass graft, with vein; subclavian-brachial

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
34802	090	11,536	23.71	RUC Time

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

35510 090 24.29 **RUC Time**

CPT Descriptor Bypass graft, with vein; carotid-brachial

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 60.6 %

TIME ESTIMATES (Median)

	CPT Code: 35523	Key Reference CPT Code: 35512	Source of Time RUC Time
Median Pre-Service Time	75.00	68.00	
Median Intra-Service Time	180.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**485.00**	**462.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	4.00
Urgency of medical decision making	3.95	3.95

Technical Skill/Physical Effort (Mean)

Technical skill required	4.55	4.50
Physical effort required	3.45	3.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.50	4.55
Outcome depends on the skill and judgment of physician	4.60	4.60

Estimated risk of malpractice suit with poor outcome	4.30	4.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	4.00
Intra-Service intensity/complexity	4.05	4.05
Post-Service intensity/complexity	3.55	3.60

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The new service under evaluation is a complex upper extremity bypass graft performed to prevent arm amputation in a patient with very advanced arterial occlusive disease and gangrene of the digits. The reconstruction is more challenging than the majority of bypass grafts because the distal target arteries - either the ulnar or the radial at the wrist, is very small in diameter and always heavily calcified due to underlying renal disease.

The survey results exhibit a tight distribution with 25th percentile at 23.00, the median survey value at 24.00 RVUs, and the 75th percentile is very close at 26.00 RVUs. The Key Reference Service 35512 (Bypass graft with vein; subclavian-brachial) is a similar operation performed in the shoulder/upper arm region. RVW of this Key Reference Service is 23.79, so the median survey for the new service is only 0.21 RVUs different at 24.00.

Does the new service deserve 0.21 more RVUs than the Key Reference? The SVS RVS Consensus Panel felt this was actually a conservative increment. Justification is provided herein.

PRE-TIME: By survey, the new service has 85 pre-service minutes, 17 more than the key reference. Our RVS committee compared the typical patient undergoing this service with the guidelines set out by the Pre-service Time Workgroup. The vignette patient has renal failure and a failed transplant. She's a lifelong smoker and virtually guaranteed to have underlying CAD and COPD. Her fingers are dying. This is about as sick as a patient can get in terms of medical co-morbidities. Her distal forearm arteries are all occluded. Successful revascularization without major complication will require marked attention to detail and collaboration with all other caregivers. This patient easily qualifies for Package 4-Difficult Patient/Difficult Procedure according to Pre-service Time Workgroup proposed guidelines. Finally, there is no way that a patient with gangrenous fingertips undergoing an arm revascularization can be positioned in 3 minutes. The arm-board needs to be located and attached to the table. Nurses and anesthesiologists need to extend the shoulder without compromising neurovascular structures. The elbow needs sufficient padding to avoid ulnar nerve compression. SVS respectfully recommends 10 minutes for pre-service positioning, therefore a total of 75 minutes, which is 10 minutes less than the survey median and 7 minutes more than Pre-Time Package 4.

INTRA-TIME: Both operations are 180 minutes in duration with identical complexity and intensity measures.

POST-TIME: Both services have the same hospital visit pattern (99232x2, 99231x1, 99238). Given the multiple advanced co-morbidities of the typical patient, and the attention to detail required, this is a conservative pattern. Both services have two 99213 office visits, while the new service has one additional 99212 visit, the number and levels

justified by requirements of attention to wound healing, patency of the bypass graft, reperfusion of the hand, return to outpatient medical balance, and care of the reperfused fingers with gangrenous fingertips.

In summary, with all elements of time and intensity nearly identical save for 7 additional pre-service minutes and one extra 99212 in the new service compared to the Key Reference, we believe the increment of 0.21 additional RVUs for the new service above that of the Reference is appropriate and easily justified.

With an RVW of 24.00, this new code will fit appropriately within the family of upper extremity bypass grafts performed using autogenous vein conduit:

CPT	Descriptor	RVW	RUC survey	Date
35511	subclavian-subclavian	22.12	YES	2000
35518	axillary-axillary	22.57	YES	2nd 5-year review 2000
35522	axillary-brachial	23.05	YES	2003
35512	subclavian-brachial	23.79	YES	2003
3552X	NEW brachial-ulnar	24.00	YES	***2007***
35516	subclavian-axillary	24.11	YES	3rd 5-year review 2005
35510	carotid-brachial	24.29	YES	2003
35506	carotid-subclavian	25.23	YES	3rd 5-year review 2005
35508	carotid-vertebral	25.99	YES	3rd 5-year review 2005
35515	subclavian-vertebral	25.99	YES	3rd 5-year review 2005

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 unlisted vascular surgery procedure

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty VS	How often? Rarely
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty VS	Frequency 100	Percentage 100.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty VS	Frequency 100	Percentage 100.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
090 Day Global Period
Facility Direct Inputs

CPT Long Descriptor: 35523 Bypass graft with vein; brachial-ulnar or -radial

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: All standard 90-day global values

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Sixty minutes has been established by a PEAC workgroup as the typical total time it takes on average across all specialties for all categories of pre-service work to get a patient into a facility for a procedure. This time has been applied to 35523.

Intra-Service Clinical Labor Activities: The assignment of 12 minutes (as supported by the PEAC) relative to coding 99238 for discharge management for inpatient services has been applied to 35523.

Post-Service Clinical Labor Activities: Standard EM post-op office visit times for clinical staff have been applied to 35523.

Supplies and Equipment – Postoperative Office Visits: Standard EM post-op supplies and equipment have been applied to 35523.

	A	B	C	D	E	F	G
1							
2				CPT Code 35523			
3	AMA/Specialty Society RVS Update Committee Recommendation			Code Descriptor: Bypass graft with vein; brachial-ulnar or -radial			
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility		
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	171.0		
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	60.0		
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	12.0		
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	99.0		
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	SERVICE PERIOD						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	**Intra-service**						
31	Assist physician in performing procedure						
32	**Post-Service**						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 –12 minutes 99239 –15 minutes	L037D	RN/LPN/MTA		12		
41	Other Clinical Activity (please specify)						
42	**End: Patient leaves office**						
43	POST SERVICE Period						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions						
46	*Office visits:*						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27		1		
50	99213 36 minutes		36		2		
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54	*Total Office Visit Time*			0	99		
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						
57	MEDICAL SUPPLIES	CMS Code	Unit				
58	pack, minimum multi-specialty visit	SA048	pack		3		
59	pack, post-op incision care (staple)	SA052	pack		1		
60	pack, non-sterile sheet, sheet 40inx60in	SB006	item		3		
61	Equipment	CMS Code	Utilization Percentage				
62	table, power	EF031			1		
63	fiberoptic exam light	EQ170			1		
64							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2006

Non-implantable Venous Access Device Blood Draws

The CPT Editorial Panel agreed that Non-implantable Venous Access Device Blood Draws is a unique new procedure, which involves specialized equipment and intense monitoring and assessment by non-physician health care professionals. This new service differs from existing codes, 36415, *Collection of venous blood by venipuncture* (work RVU = 0.00) and 36540, *Collection of blood specimen from a completely implantable venous access device* (work RVU = 0.00). There are not currently codes to describe blood draw via other routes such as Percutaneous Inserted Central Catheter (PICC) lines and peripheral IVs. To do so, CPT created three new codes, 36591, *Collection of blood specimen from a completely implantable venous access device*, 36592, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified*, and 36593, *Declotting by thrombolytic agent of implanted vascular access device or catheter.*

The RUC reviewed the non-facility practice expense inputs carefully focusing on the typical patient encounter. The RUC believed, and the specialty agreed, that the clinical labor times initially presented to the RUC were too high for the typical patient encounter. The RUC reduced specific clinical labor activity line items to recommend a total clinical labor time of 19 minutes for code 36591, 15 minutes for 36592, and 37 minutes for 36593. The RUC established a detailed allocation of the clinical labor time in the non-facility setting and no direct practice expense inputs in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
Venipuncture, needle or catheter for diagnostic study or intravenous therapy, percutaneous. These codes are also used to report the therapy as specified. For collection of a specimen from an established catheter use 36592. For collection of a specimen from a completely implantable venous access device use 36591.					
36400		*Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine*	XXX	3 1992 Work RVU=0.19 6 93-01 Work RVU=0.18 7 2002 Work RVU=0.38	0.38 (No Change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		venipuncture; femoral or jugular vein		6 03-06 Work RVU=0.38	
36405		*scalp vein*	XXX	3 1992 Work RVU=0.19 6 93-01 Work RVU=0.18 7 2002 Work RVU=0.31 6 03-06 Work RVU=0.31	0.31 (No Change)
D 36540		~~Collection of blood specimen from a completely implantable venous access device~~ ~~(Do not report 36540 in conjunction with 36415, 36416)~~ ~~(For collection of venous blood specimen by venipuncture, use 36415)~~ ~~(For collection of capillary blood specimen, use 36416)~~	XXX	N/A	N/A
D 36550		~~Declotting by thrombolytic agent of implanted vascular access device or catheter~~ (36540 has been deleted. To report see 36591) (36550 has been deleted. To report see 36593)	XXX	N/A	N/A
Central Venous Access Procedures *To qualify as a central venous access catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium. The venous access device may be either centrally inserted (jugular, subclavian……* ***Removal of Central Venous Access Device***					
36589		Removal of tunneled central venous catheter, without subcutaneous port or pump	010	7 2004 Work RVU=2.27 6 04-06 Work RVU=2.27	2.27 (No Change)
⊙36590		Removal of tunneled central venous access device,	010	7 2004 Work RVU=3.30 6 04-06 Work RVU=3.30	3.30

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		with subcutaneous port or pump, central or peripheral insertion (Do not report 36589 or 36590 for removal of non-tunneled central venous catheters)			(No Change)
Other Central Venous Access Procedures					
●36591 Renumbered Code from 36540		Collection of blood specimen from a completely implantable venous access device (Do not report 36591 in conjunction with any other service) (For collection of venous blood specimen by venipuncture, use 36415) (For collection of capillary blood specimen, use 36416)	XXX	N/A	0.00 (No Physician Work – PE Inputs Only)
●36592	B1	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified (For blood collection from an established arterial catheter use 37799) (Do not report 36592 with any other service)	XXX	N/A	0.00 (No Physician Work – PE Inputs Only)
●36593 Renumbered from 36550		Declotting by thrombolytic agent of implanted vascular access device or catheter	XXX	N/A	0.00 (No Physician Work – PE Inputs Only)
~~**Mechanical Removal of Obstructive Material**~~					

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
36595		Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access (Do not report 36550 in addition to 36595) (For venous catheterization, see 36010-36012) (For radiological supervision and interpretation, use 75901)	000	7 2004 Work RVU=3.59 6 04-06 Work RVU=3.59	3.59 (No Change)
36596		Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen (Do not report 36550 in addition to 36596) (For venous catheterization, see 36010-36012) (For radiological supervision and interpetation, use 75902)	000	7 2004 Work RVU=0.75 6 04-06 Work RVU=0.75	0.75 (No Change)
~~Other Central Venous Access Procedures~~					
36597		Repositioning of previously placed central venous catheter under fluoroscopic guidance (For fluoroscopic guidance, use 76000)	000	7 2004 Work RVU=1.21 6 04-06 Work RVU=1.21	1.21 (No Change)
36598		Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report (Do not report 36598 in conjunction with 76000) (Do not report 36598 in conjunction with 36595,	000	7 2006 Work RVU=0.74	0.74 (No Change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		36596) (For complete diagnostic studies, see 75820, 75825, 75827)			

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CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: 36592 – Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified

Sample Size:_N/A___ Response Rate: (%):_N/A___ Global Period:_XXX_

Geographic Practice Setting %: N/A Rural____ Suburban_____ Urban_____

Type of Practice %: N/A
_____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Clinical Oncology (ASCO) convened a consensus panel to develop direct practice expense inputs for 36592. The consensus panel included two oncology certified nurses who are active volunteers with the Oncology Nursing Society (ONS) and two medical oncologists. The composition of the panel was geographically diverse, with panel members hailing from California, Tennessee, Texas, and Massachusetts.

As this procedure is typically performed by nurses, the ONS participants were asked to conduct the preliminary analysis of the clinical staff times and supplies associated with this service. The full consensus panel then convened by conference call to review and finalize the recommendations for each of the inputs.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

There are no pre-service clinical labor activities related to this service.

Intra-Service Clinical Labor Activities:

The RN reviews the patient charts for orders and obtains medical history (e.g., chemotherapy-related history). Patient is greeted, gowned, and positioned for blood draw. The physician is typically not involved with performing the actual procedure of the blood draw. Rather, this is completed by the RN so 4 minutes of nursing time has been included for the intra-service period under "Assist physician in performing procedure". This 4 minutes of time includes the following components: 1) drawing a 10 cc syringe full to discard, 2) drawing a second syringe to collect blood specimen, and 3) flushing the line. Following the procedure, the RN completes requisite clinical forms and cleans the room. The RN labels the blood specimen and places it in the appropriate container for transport to the clinical laboratory.

Post-Service Clinical Labor Activities:

There are no post-service clinical labor activities associated with this service.

	A	B	C	D	E	F
1						
2						
3				36592		
4	**Meeting Date: October 2006** **Specialty: Oncology**			**Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified**		
5	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	
6	**GLOBAL PERIOD**			**XXX**		
7	**TOTAL CLINICAL LABOR TIME**	**L051A**	**RN**	**23**	**0**	
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**23**	**0**	
10	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	
11	**PRE-SERVICE**					
12	**Start: Following visit when decision for surgery or procedure made**					
13	Complete pre-service diagnostic & referral forms			**0**	**0**	
14	Coordinate pre-surgery services			**0**	**0**	
15	Schedule space and equipment in facility			**0**	**0**	
16	Provide pre-service education/obtain consent			**0**	**0**	
17	Follow-up phone calls & prescriptions			**0**	**0**	
18	Other Clinical Activity (please specify)			**0**	**0**	
19	**End:When patient enters office/facility for surgery/procedure**					
20	**SERVICE PERIOD**					
21	**Start: When patient enters office/facility for surgery/procedure**					
22	**Pre-service services**					
23	Review charts			**2**	**0**	
24	Obtain related medical history			**2**	**0**	
25	Greet patient and provide gowning			**3**	**0**	
26	Obtain vital signs			**0**	**0**	
27	Provide pre-service education/obtain consent			**0**	**0**	
28	Prepare room, equipment, supplies			**4**	**0**	
29	Setup scope (non facility setting only)			**0**	**0**	
30	Prepare and position patient/ monitor patient/ set up IV			**2**	**0**	
31	Sedate/apply anesthesia			**0**	**0**	
32	**Intra-service**					
33	Assist physician in performing procedure			**4**	**0**	
34	**Post-Service**					
35	Monitor pt. following service/check tubes, monitors, drains			**0**	**0**	
36	Clean room/equipment by physician staff			**3**	**0**	
37	Clean Scope			**0**	**0**	
38	Clean Surgical Instrument Package			**0**	**0**	
39	Complete diagnostic forms, lab & X-ray requisitions			**3**	**0**	
40	Review/read X-ray, lab, and pathology reports			**0**	**0**	
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			**0**	**0**	
42	Discharge day management 99238 --12 minutes 99239 --15 minutes			**0**	**0**	
43	Other Clinical Activity (please specify):			**0**	**0**	
44	**End: Patient leaves office**				-	
45	**POST-SERVICE Period**					
46	**Start: Patient leaves office/facility**					

	A	B	C	D	E	F
3				36592		
4	**Meeting Date: October 2006** **Specialty: Oncology**			**Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified**		
5	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	
47	Conduct phone calls/call in prescriptions			**0**	**0**	
48	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care					
49	*List Number and Level of Office Visits*					
50	99211 16 minutes		16	**0**	**0**	
51	99212 27 minutes		27	**0**	**0**	
52	99213 36 minutes		36	**0**	**0**	
53	99214 53 minutes		53	**0**	**0**	
54	99215 63 minutes		63	**0**	**0**	
55	Other					
56						
57	*Total Office Visit Time*			**23**	**0**	
58	Other Activity (please specify)					
59	**End: with last office visit before end of global period**					

	A	B	C	D	E	F
3				36592		
4	**Meeting Date: October 2006** **Specialty: Oncology**			**Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified**		
5	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	
60	**MEDICAL SUPPLIES**	**CMS Code**				
61	gloves, sterile	SB024		**1**	**0**	
62	paper, exam table	SB036		**7**	**0**	
63	underpad 2 ft x 3 ft (Chux)	SB044		**1**	**0**	
64	syringe w-needle, OSHA compliant (SafetyGlide)	SC058		**2**	**0**	
65	color coded cap and vial (for antigen)	SL027		**3**	**0**	
66	label for microscope slides	SL085		**6**	**0**	
67	chloraprep patient prep swabs 1.5 ml **	New		**3**	**0**	
68	swab-pad, alcohol	SJ053		**7**	**0**	
69	sodium chloride 0.9% inj bacteriostatic (30 ml uou)	SH068		**1**	**0**	
70	eye shield, non-fog	SG049		**1**	**0**	
71	gown, patient	SB026		**1**	**0**	
72	heparin lock	SC012		**1**	**0**	
73	syringe, 5-6 ml	SC057		**1**	**0**	
74	heparin lock flush solution	SH040		**1**	**0**	
76	gauze, non-sterile 2 in x 2 in	SG050		**4**	**0**	
77	syringe 10-12 ml	SC051		**2**	**0**	
78						
79	**Equipment**	**CMS Code**	**Unit**			
80	Table, exam	EF023	1	**23 min**	**0**	
81						
82	**Pricing information attached.					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Arterial Catheterization

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they determined should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 36620 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 36620 to the RUC. Code 36620 had never been surveyed nor discussed at the RUC previously. The RUC understands that it is tasked with considering whether 36620 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 36620.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post service periods which would disqualify 36620 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

After significant discussion, the RUC determined that the specialty society recommended pre-service time did not accurately reflect the service and decreased it from 13 minutes to 7 minutes, while retaining the post-operative time at 5 minutes. **Due to this detailed review of the pre-service and post-service time to ensure no dupliction with other services reported on the same date, the RUC recommends that 36620 be retained on the Modifier -51 Exempt List.**

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As the RUC works under the presumption that all services on the RBRVS are correctly valued unless evidence is produced to re-value, the specialty society provided compelling evidence to support its recommendation of 1.50 work RVUs, which is an increase over the existing value of 36620, 1.15 work RVUs. The RUC reviewed this compelling evidence and did not agree with the specialty that there was evidence that incorrect assumptions were made in the previous evaluation of this service. **Therefore, the RUC recommends that the new times, 7 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time be associated with 36620 and that the existing value of 1.15 work RVUs be retained for this procedure.**

Practice Expense:
The RUC recommends that the practice expense inputs be retained for this procedure, which is zero direct PE inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲⊘36620	DD3	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	000	1.15 (No Change)

1092

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

PT Code:36620 Tracking Number DD3 Specialty Society Recommended RVU: **1.50**
Global Period: 000 RUC Recommended RVU: **1.15**

CPT Descriptor: Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman is admitted to the hospital because of pneumonia, fever, septic shock, hypoxemia and agitation. An arterial catheter is inserted, both to monitor blood pressure and to obtain frequent arterial blood samples

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 33%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service includes: reason for procedure explained to patient and sometimes family; patient informed of benefits and possible complications and risks of procedure and potential access sites examined.

Description of Intra-Service Work: The puncture site is prepared with appropriate antiseptic, the artery is located and fixed and a needle with intracatheter is inserted into the target artery. The catheter is threaded into the artery and the edle is withdrawn. A blood sample is taken for Arterial Blood Gas analysis and the catheter is irrigated with saline and an obturator is inserted into the catheter which is then fixed to the skin. Depending upon hospital protocol this fixation may include sutures. If the arterial catheter is to be used for monitoring, an arterial monitoring line is connected and functionality is assessed.

Description of Post-Service Work: The catheter and puncture site are inspected and the radial pulse is palpated. The patient is then given detailed follow-up instructions regarding the care, future monitoring and withdrawal of blood samples. Note that as long as the catheter is in place, daily monitoring and withdrawal of blood samples will take place. A procedure note is written in the medical chart and appropriate orders are written for care of the catheter site.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Tripti Kataria, MD, MPH				
Specialty(s):	American Society of Anesthesiologists				
CPT Code:	36620				
Sample Size: 250	**Resp N:** 42	**Response:** 16.8 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	21.25	**60.00**	100.00	400.00
ırvey RVW:	0.99	1.50	**1.80**	2.00	2.98
re-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**3.0**		

CPT Code: 36620

Intra-Service Time:		2.00	5.00	**10.00**	14.00	20.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

ɔwever, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 36620	
	Specialty Recommended
Physician Work RVU:	1.50
Pre-Service Evaluation Time:	2.0
Pre-Service Positioning Time:	2.0
Pre-Service Scrub, Dress, Wait Time:	3.0
Intra-Service Time:	10.00

Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36625	000	2.11	Harvard Time

CPT Descriptor Arterial catheterization or cannulation for samplling, monitoring or transfusion (separate procedure); cutdown

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
36556	000	654,136	2.50	RUC Time

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter:; age 5 years or older

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
'1755	000	22,576	1.31	RUC Time

CPT Descriptor 2 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
64447	000	1.50	RUC Time

CPT Descriptor Injection, anesthetic agent; femoral nerve, single

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 57.1 %

TIME ESTIMATES (Median)

	CPT Code: 36620	Key Reference CPT Code: 36625	Source of Time Harvard Time
Median Pre-Service Time	7.00	11.00	
Median Intra-Service Time	10.00	29.00	
Median Immediate Post-service Time	5.00	7.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**22.00**	**47.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.83	3.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.13
Urgency of medical decision making	3.17	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.88
Physical effort required	2.83	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.21	3.42
Outcome depends on the skill and judgment of physician	3.33	3.50

Estimated risk of malpractice suit with poor outcome	3.04	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.88	2.96
Intra-Service intensity/complexity	3.25	3.67
Post-Service intensity/complexity	2.67	2.96

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The code comes to the RUC as a result of the CPT review of codes listed in Appendix E—Summary of Codes Exempt om Modifier 51. The Panel agreed that the code met the criteria to remain in this appendix.

While 33% of our respondents indicated that moderate sedation was typical for this procedure, we maintain that it is not inherent to the procedure. Patients may receive "light sedation" and our respondents may have been confused about all the elements inherent in moderate sedation.

Code 36620 was last reviewed by the RUC during the second Five Year Review. In its recommendation to CMS (per the June 8, 2001 Federal Register, p 31062) the RUC stated, ***"With respect to 36620, the RUC compared this procedure to the reference service (code 36140) and agreed that this service appeared to be undervalued. However, the RUC was concerned that anesthesiologists who perform this procedure over 80 percent of the time did not comment or participate in the survey conducted by the specialty groups".***

Pulmonary Disease surveyed this code for the second Five Year Review. Their survey median was 2.01 work RVUs - a value that is essentially equal to the 75th percentile in our survey. Their survey times were higher than those reported by our respondents. Our survey confirms the RUC's opinion that the code is undervalued and we recommend that the code be assigned 1.50 work RVUs – our survey's 25th percentile.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) This code is listed in CPT Appendix E - Summary of CPT Codes Exempt from Modifier 51. It describes a service/procedure that is sometimes a stand alone procedure, but it is typicall adjunctive. Anesthesia (by far the predominant specialty) performs this as a stand alone procedure approximately 40% of the time.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
Anesthesioloigsts perform this most frequently in conjunction with an anesthesia service (00100-01999) Per CMS and CPT, placement of invasive monitoring devices is separate and distinct from an anesthesia service. Critical care physicians may report other procedures such a insertion of a pulmonary artery catheter (93503) and intubation (31500) along with this service.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 36620

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesia	How often? Commonly
Specialty Pulmonary Disease	How often? Rarely
Specialty Critical Care	How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 2487576
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We expect that anesthesiologists would perform a higher precentage of arterial lines in younger (non-Medicare) patients, as art lines are more commonly associated with surgery in younger age groups

Specialty Anesthesia	Frequency 2363198	Percentage 95.00 %
Specialty Pulmonary Disease	Frequency 49752	Percentage 2.00 %
Specialty Critical Care	Frequency 24876	Percentage 1.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 621,894 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This Medicare frequency information is taken from the RUC Database

Specialty Anesthesia	Frequency 559704	Percentage 89.99 %
Specialty Pulmonary Disease	Frequency 14492	Percentage 2.33 %
Specialty Critical Care	Frequency 8706	Percentage 1.39 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. The RUC recommends that the current PLI be utilized for 36620.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor: **36620 – Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Anesthesiologists conducted a RUC survey for code 36620 – Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous. The practice expense units were deemed to be unchanged and we recommend keeping the current inputs of o clinical labor minutes, no supplies and no equipment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

none

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

none

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **36620 – Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Anesthesiologists conducted a RUC survey for code 36620 – Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous. The practice expense units were deemed to be unchanged and we recommend keeping the current inputs of zero clinical labor minutes, no supplies and no equipment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1							
2				CPT Code - 36620		CPT Code	
3	Meeting Date: April 2007			Code Descriptor - Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous		Code Descriptor	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			0	0		
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	SERVICE PERIOD						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	**Intra-service**						
31	Assist physician in performing procedure						
32	**Post-Service**						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 –12 minutes 99239 –15 minutes						
41	Other Clinical Activity (please specify)						
42	**End: Patient leaves office**						
43	POST-SERVICE PERIOD						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions						
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54							
55	*Total Office Visit Time*			0	0	0	0
56	Other Activity (please specify)						
57	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
2				CPT Code - 36620		CPT Code	
3	Meeting Date: April 2007			Code Descriptor - Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous		Code Descriptor	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES	CMS Code	Staff Type				
59	No Supplies	SX007					
60							
61							
62							
63							
64							
65							
66	Equipment	CMS Code	Utilization Percentage				
67	No Equipment	EZ007					
68							
69							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Head and Neck Interstitial Brachytherapy Needle or Catheter Placement

In February 2007, the CPT Editorial Panel created a new CPT code to describe surgical placement of brachytherapy needles or catheters in the head and/or neck region.

The RUC reviewed the survey results from 50 radiation oncologists for new CPT code 41019 *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application* and the specialty's key reference code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (work RVU 13.31, 090 day global). The RUC concurred that the survey respondents over estimated the physician work for this new 000 day global procedure, and the physician time appeared to be overstated in the pre-service time period.

The RUC determined that new code 41019 requires the same physician work, time, and intensity as code 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU = 8.84). In addition, the RUC believed that the pre-service physician time should be reduced by a total of 25 minutes, to reflect the typical patient evaluation and positioning time. The RUC determined that the typical patient would require pre-service evaluation time of 30 minutes, positioning of 10 minutes, and 15 minutes for scrub, dress, and wait, intra-service time of 90 minutes and an immediate post service time of 30 minutes, for code 41019.

The RUC recommends a physician work relative value of 8.84 for CPT code 41019.

Practice Expense

The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service.

1105

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●41019	II1	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application (Report supply of device separately) (For imaging guidance, see 76942, 77002, 77012, 77021) (For stereotactic insertion of intracranial brachytherapy radiation sources, see 61770) (For interstitial radioelement application, see 77776-77784)	000	N/A	8.84

1106

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:41019 Tracking Number II1 Specialty Society Recommended RVU: **11.00**
Global Period: 000 RUC Recommended RVU: **8.84**

CPT Descriptor: Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral or transnasal) for subsequent interstitial radioelement application.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year old man, with a history of cigarette and alcohol abuse presents with weight loss, dysphagia, and pain. A 3 cm tumor is identified in the base of tongue adjacent to the faucial arch of tonsil. Neck nodes are clinically negative and PET scan shows no metastasis. Following external beam irradiation with concurrent chemotherapy, a brachytherapy boost procedure is scheduled.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 32%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review of initial exams, radiation and chemotherapy records including related toxicities and labs. Obtain consent and educate patient and family about procedure. Review preoperative imaging and plan catheter placement. Discuss implant volume, placement and spacing with the brachytherapy team. Select, assemble, and if necessary order requisite brachytherapy catheters and supplies. Dress, scrub and wait. Discuss airway management with anesthesiologist.

Description of Intra-Service Work: After induction of general anesthesia with nasotracheal intubation, the patient is positioned and stabilized affording comfortable intraoral access and exposure of the neck and face. Visual and bimanual examination is performed to assess residual tumor volume and residual chemo/radiation reactions. Wax protection is fashioned for the remaining teeth. Shave, scrub, and drape are performed. The relationship of the tumor to normal structures including the hyoid bone, mandible, and carotid arteries is determined, and the are projections drawn on the skin. The proposed catheter entrance sites are marked, and an appropriate number of catheters, fixing buttons and silk ties are selected and assembled.

The oral cavity and oropharynx are suctioned and rinsed. Initial skin punctures are made according to the locations drawn submentally, with 17 gauge 30 degree bevel needles, and advanced along a trajectory aiming for the selected exit point within the oropharynx, through the muscle. A double gloved finger monitors the position of the tumor, the target position for the catheter, and the needle tip. An alternate series of advances and palpations are performed until the needle tip is in the desired position just beneath the mucosa of the base of tongue. The finger is withdrawn and the needle advanced until it exits from the tongue into the oropharnynx. A 26-gauge surgical steel wire is inserted into the external portion of the needle and advanced until it can be palpated internally. Its tip is then brought out through the oral cavity with the proximal end clamped to prevent it from being lost into the needle. The leader portion of the catheter tube, button, and silk tie is then threaded over the wire. A tonsil clamp is applied to the leader and wire. The assembly is then pulled from the submental region until the leader portion of the catheter is visible, and the button end of the tube pulled into the oral cavity and down onto the dorsal surface of the tongue. The silk tie is brought out through the oral cavity and set aside. The external portion of the catheter is held in position by placing a hemispherical color coded button on the leader and bringing the rounded end snugly to the skin.

This process is repeated for each of the 25 needles according to the implant volume. Strict spacing is assessed visually on the skin and by palpation within the oropharynx and oral cavity. Catheters are removed and replaced as necessary to ensure the geometry. Frequent irrigation and suctioning is performed to maintain a clean dry field. The excess catheter and leader projecting beyond the fixing buttons are cut to the desired length and discarded. The inner catheter ribbons

(for stabilizing the catheter during insertion) are individually removed with wire strippers and discarded. The silk ties are gathered outside the oral cavity, and tied together with another silk tie. The group is then pulled through a Penrose type drain, and externally secured with tape. The face and neck are cleansed and the exit sites of the catheter are painted with triple antibiotic ointment.

Description of Post-Service Work: The physician diagrams the implant in the patient's medical record; dictates the procedure report and writes orders. The patient is examined, paying close attention to the patient's airway and catheter wounds. The physician communicates with physics/dosimetry staff regarding subsequent radioelement application. Answers patient and family questions. Coordinates post operative imaging. Answers nursing and other staff questions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Najeeb Mohideen, M.D., Michael Kuettel, M.D., MBA, PhD, David Beyer, M.D.					
Specialty(s):	Radiation Oncology					
CPT Code:	41019					
Sample Size: 595	**Resp N:** 50	**Response:** 8.4 %				
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	1.25	**3.00**	5.00	75.00
Survey RVW:		6.00	12.63	**15.00**	17.00	49.00
Pre-Service Evaluation Time:				**50.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	60.00	**90.00**	90.00	200.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 41019	
	Specialty Recommended
Physician Work RVU:	8.84
Pre-Service Evaluation Time:	30.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	15.0
Intra-Service Time:	90.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55875	090	13.31	RUC Time

CPT Descriptor Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
43269	000	15,294	8.20	RUC Time

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 62.0 %

TIME ESTIMATES (Median)

	CPT Code: 41019	Key Reference CPT Code: 55875	Source of Time RUC Time
Median Pre-Service Time	55.00	50.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**175.00**	**249.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.32	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.36	3.52
Urgency of medical decision making	4.22	3.29

Technical Skill/Physical Effort (Mean)

Technical skill required	4.92	4.32
Physical effort required	4.58	3.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	4.03
Outcome depends on the skill and judgment of physician	4.92	4.35

Estimated risk of malpractice suit with poor outcome	4.50	4.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.20	3.84
Intra-Service intensity/complexity	4.82	4.03
Post-Service intensity/complexity	4.40	3.68

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Fifty physician work surveys were completed by our membership for this new CPT code. The data from those surveys were collected, reviewed and analyzed by a consensus panel, consisting of members of ASTRO's Health Policy and Code Development and Valuation Committee, as well as brachytherapy experts in the field of radiation oncology. The group reviewed the survey data and recommends a work RVU of 11.0 for this new procedure code, a value less then the 25th percentile.

The panel reviewed the data for this new CPT code, along with the reference service code and the two other new CPT codes for similar procedures, being presented at this RUC meeting. And although the panel agreed with the survey respondents that the RVU should be established at a rate higher then the panel is recommending, the survey response times, along with the surveyed RVU recommendations, create an IWPUT that would create a rank order anomaly. The panel has reviewed the family of these codes and feels that following is an appropriate rank order:

Surveyed Code:*(this survey)*	**41019**	**IWPUT 0.09723**
Reference Service Code:	55876	IWPUT 0.09482
Surveyed Code:	55920	IWPUT 0.09167
Surveyed Code:	20555	IWPUT 0.083

The panel feels the procedure described by this new CPT code is more intense then the work described in the reference service code.

The panel recommends the median survey times for this procedure (*one exception) and recommends they be entered into the RUC database: 20 minutes of pre-service evaluation time, 15 minutes for pre-service positioning, 15 minutes for pre-service scrub, dress and wait , 90 minutes of intra-service time, and 30 minutes of immediate post-service time. The society recommends 30 minutes day preceding procedure be entered into the RUC database, instead of the median of 42.5 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT Code: 77014; Computed tomography guidance for placement of radiation therapy fields
Global Period: XXX
Work RVUs: TC-Only
Total Time: 17 minutes

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
41599; Unlisted procedure, tongue, floor of mouth
42999; Unlisted procedure, pharynx, adenoids, or tonsils

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology How often? Sometimes

Specialty Head and Neck Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. This type of procedure will most likely be performed by a radiation oncologist, but occassionally could be performed by a surgeon and therefore we have indicated that below.

Specialty Radiation Oncology Frequency 360 Percentage 90.00 %

Specialty Head and Neck Surgery Frequency 40 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 265
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the total number of times this service us provided annually, the recipient is an elderly patient, and as stated above, will most likely be performed by a radiation oncologist.

Specialty Radiation Oncology	Frequency 240	Percentage 90.56 %
Specialty Head and Neck Surgery	Frequency 25	Percentage 9.43 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 77763

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor: Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral or transnasal) for subsequent interstitial radioelement application.

Sample Size: N/A **Response Rate: (%):** N/A **Global Period:** 000

EXPERT PANEL USED TO DEVELOP RECOMMENDATION

Geographic Practice Setting %: **All geographic practice settings represented.**

Type of Practice %: **All practice types represented.**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Therapeutic Radiology and Oncology (ASTRO) prepared these practice expense reccommendations using a consensus panel of physicians comprised of members from ASTRO's Health Policy Committee, Code Development and Valuation Committee (CDVC), as well as those physicians that perform brachytherapy implant placement procedures. The consensus panel included physician representatives from states in various regions of the United States and all demographic areas.
The consensus panel members held several conference calls to evaluate the non-physician clinical labor times, medical supplies, and equipment, based upon the panel members' experience with the procedure under consideration. Preliminary recommendations for direct inputs were drafted and distributed for discussion by the panel during these conference calls, which led to the final formulated practice expense recommendations for CPT® Code 41019; *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral or transnasal) for subsequent interstitial radioelement application.*. Although ASTRO was also scheduled to make non-facility practice expense recommendations for this procedure, we felt that it was appropriate to only make recommendations for the facility setting at this time.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Schedule procedure, confirm all applicable supplies and devices are available.

Retrieve and compile all relevant clinical information, including all preoperative imaging studies, and patient's medical record for review by the physician. Verify orders, and confirm procedure protocol with physician.

Contact patient on the day before the procedure to provide educational information regarding the procedure and provide them with any additional information they may request. Obtain informed consent and confirm adherence to pre procedure protocol.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Initiate phone calls for physician and call in prescriptions as applicable.

	A	B	C	D	E
2				41019	
3	**April 2007** **AMA/Specialty Society RVS Update Society Recommendation**			*Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral or transnasal) for subsequent interstitial radioelement application.*	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**33.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**30.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**3.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms	**L037D**	**RN/LPN/MTA**		**5**
13	Coordinate pre-surgery services	**L037D**	**RN/LPN/MTA**		**10**
14	Schedule space and equipment in facility	**L037D**	**RN/LPN/MTA**		**5**
15	Provide pre-service education/obtain consent	**L037D**	**RN/LPN/MTA**		**7**
16	Follow-up phone calls & prescriptions	**L037D**	**RN/LPN/MTA**		**3**
17	Other Clinical Activity (please specify)				
18	**End:When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning	**L037D**	**RN/LPN/MTA**		
24	Obtain vital signs	**L037D**	**RN/LPN/MTA**		
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies	**L037D**	**RN/LPN/MTA**		
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV	**L037D**	**RN/LPN/MTA**		
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure	**L037D**	**RN/LPN/MTA**		
32	**Post-Service**				
33	Monitor pt. following service/check tubes, monitors, drains	**L037D**	**RN/LPN/MTA**		
34	Clean room/equipment by physician staff	**L037D**	**RN/LPN/MTA**		
35	Clean Scope	**L037D**	**RN/LPN/MTA**		
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	**RN/LPN/MTA**		
40	Discharge day management 99238 --12 minutes 99239 --15 minutes				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				
43	**POST-SERVICE PERIOD**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions	**L037D**	**RN/LPN/MTA**		**3**
46	*Office visits:*				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		**16**		
49	99212 27 minutes		**27**		
50	99213 36 minutes		**36**		
51	99214 53 minutes		**53**		
52	99215 63 minutes		**63**		
53	Other				
54	*Total Office Visit Time*			**0**	**0**
55	Other Activity (please specify)				
56	**End: with last office visit before end of global period**				
57	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
58	pack, drapes, cystoscopy	**SA045**	**pack**		
59	pack, minimum multi-specialty visit	**SA048**	**pack**		
60	syringe 20ml	**SC053**	**item**		
61	needle, spine, Sprotte	**SC042**	**item**		
62	cover-condom, transducer or ultrasound probe	**SB005**	**item**		
63	kit, gold markers, fiducial, 3 per kit	**N/A**	**kit**		
64	lidocaine 1%-2% inj (Xylocaine)	**SH047**	**ml**		
65	**Equipment**	**CMS Code**			
66	table, power	**EF031**			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Peritoneal Tumor Ablation

In April 2006, the RUC reviewed new codes 58957 *Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;* (work RVU = 26.06) and 58958 *Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy* (work RVU = 29.06). Codes 58957 and 58958 had been split out from CPT codes 49200 *Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas;*(work RVU = 10.94) and 49201 *Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive* (work RVU = 15.67). The RUC determined that 49200 and 49201 should be reviewed for potential work neutrality, but first requested a review by general surgery. The RUC asked general surgery to survey code 49200 and 49201 for presentation in October 2006.

General surgery attempted to survey the codes for the October 2006 RUC meeting, however it was determined that the vignettes and CPT descriptors were confusing to the survey participants. The specialty indicated that they needed to first address new coding for these services, resulting in the replacement of 49200 and 49201 with three new codes. When these codes were initially created and valued, during the Harvard review, the typical patient was described as on one who had three lymphatic cysts removed. Today lymphatic cysts are treated by less evasive means. The typical patient today has a tumor which is removed openly. The specialty indicated that they needed to accurately describe the codes in CPT. The RUC agreed that coding changes were needed prior to the survey, and in February 2007 the CPT Editorial Panel deleted codes 49200 and 49201 and replaced them with three new codes to report resection and debulking of specific recurrent malignancies. The RUC agreed with the specialty that the typical patient had changed so that the current codes could not describe the procedures being performed. The RUC determined that there was compelling evidence that these services were never described or valued properly.

For the April 2007 RUC meeting, the ACS independently surveyed the three new codes (49203, 49204, 49205) while the ACOG independently surveyed 49203 and 49204. The RUC determined that the vignette used by the American College of Obstetricians and Gynecologists (ACOG) would not be used as it was not vetted through the standard CPT Editorial Panel Process.

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49203
The committee reviewed the ACS survey data for 49203 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less* and compared it to the reference code as selected by the ACS survey respondents, 44140 *Colectomy, partial; with anastomosis* (Work RVU=22.46). The surveyed code has significantly less intra-service time as compared to the reference code, 120 minutes and 150 minutes, respectively. Additionally, the RUC determined that the surveyed code is a less intensive procedure to perform than its reference code. Therefore, because the surveyed code has less intra-service time and is a less intensive procedure to perform in comparison to the reference code, the RUC recommends the 25th percentile of the survey data, 20.00 work RVUs.

The RUC recommends a physician work relative value of 20.00 RVUs for CPT code 49203.

49204
The committee reviewed the ACS survey data for 49204 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less; largest tumor 5.1 to 10.0 cm diameter* and compared it to multi-specialty points of comparison reference code, 44140 *Colectomy, partial; with anastomosis* (Work RVU=22.46). The committee reviewed all of the surveyed times for this procedure and determined that the post-operative visits of the surveyed code should mirror the post-operative visits of the reference code, as the distribution of the reference code's post-operative visits seemed to better reflect the post-operative care of the surveyed code. Therefore, the committee recommends that one 99232 hospital visit be transitioned to a 99231 hospital visit, resulting in one 99232 hospital visit and five 99231 hospital visits for the surveyed code. Further, the committee reviewed the other service times associated with this code and noted that the surveyed code has more intra-service time associated with it than the reference code (160 minutes and 150 minutes, respectively) and that the surveyed code has more pre-service time than the reference code (81 minutes and 60 minutes, respectively). Additionally, the RUC determined that the surveyed code is a more intensive procedure to perform than the reference code. Therefore, because the surveyed code has more pre-service and intra-service time and is a more intensive procedure to perform than the reference code, the RUC recommends the median of the survey data, 26.00 work RVUs.

The RUC recommends a physician work relative value of 26.00 RVUs for CPT code 49204.

49205
The committee reviewed the ACS survey data for 49205 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less; largest tumor greater than 10.0 cm diameter* and compared it to two reference codes as selected by the ACS respondents, 43633 *Gastrectomy, partial, distal; with Roux-en-Y reconstruction* (Work RVU=33.01) and 58957 *Resection (tumor debulking) of recurrent*

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ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; (Work RVU=26.06). The committee used these two codes as anchors to develop work RVU recommendations for 49205. The committee compared the total service times of all three codes and noted that the total service time for the surveyed code fell between the two reference codes (Total Time, 43633: 740 minutes; 49205: 645 minutes and 58957: 552 minutes). Further, the committee noted that the intensity of performing the surveyed code fell between the two reference codes. Therefore, because the surveyed code fell between the two reference codes in times and intensities, the RUC recommends the median survey value, 30.00 work RVUs for code 49205.

The RUC recommends a physician work relative value of 30.00 RVUs for CPT code 49205.

Practice Expense

The RUC recommends no direct practice expense inputs in the non-facility setting for these facility only services. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service based on the 90 day global RUC standards.

1121

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 49200		~~Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas;~~	090	N/A
D 49201		~~extensive~~ (For open cryoablation of renal tumor, use 50250) (For percutaneous cryotherapy ablation of renal tumors, use Category III code 0135T) (49200, 49201 have been deleted. To report, see 49203-49205, 58957, 58958)	090	N/A
●49203	JJ1	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less	090	20.00

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●49204	JJ2	largest tumor 5.1 to 10.0 cm diameter	090	26.00
●49205	JJ3	largest tumor greater than 10.0 cm diameter (Do not report 49203-49205 in conjunction with 38770, 38780, 49000, 49010, 49215, 58900-58960, 50010, 50205, 50225, 50236, 50250, 50290)) (For partial or total nephrectomy, use 50240 or 50220 in conjunction with 49203-49205) (For colectomy, use 44140 in conjunction with 49203-49205) (For small bowel resection, use 44120 in conjunction with 49203-49205) (For vena caval resection with reconstruction, use 37799 in conjunction with 49203 - 49205)	090	30.00
Surgery **Female Genital System** **Ovary** **Excision**				
58957		Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;	090	26.07 (No Change)
58958		with pelvic lymphadenectomy and limited para-aortic lymphadenectomy (Do not report 58957, 58958 in conjunction with 38770, 38780, 44005, 49000, 49203-49215, 49255, 58900-58960)	090	29.06 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49203 Tracking Number JJ1 Specialty Society Recommended RVU: **19.69**
Global Period: 090 RUC Recommended RVU: **20.00**

CPT Descriptor: Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less

---

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 42-year-old male had a prior abdominal resection for peritoneal mesothelioma. Two years after that, he presents with at least three 2-cm. masses in the right retroperitoneum and at exploration has four other 1-2 cm. nodules.

Percentage of Survey Respondents who found Vignette to be Typical:

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Write orders for preoperative medications including beta blockers, if indicated.
- Review pre-operative work-up, with particular attention to imaging information and reports.
- Review results of preoperative testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Confirm with nurses and patient that this will be done with an abdominal midline incision and there is no sidedness.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:
Skin incision is made using sharp dissection. Hemostasis is achieved using electrocautery and small ligatures, as necessary. The linea alba is identified and carefully divided. The peritoneum is grasped, elevated, and carefully incised to avoid injury to bowel. The peritoneal cavity is entered under direct vision. Adhesions are cleared by sharp dissection in order to expose all of the abdominal viscera. A visual and manual complete exploration of the abdominal cavity and its contents is carried out. The NG tube is placed and its position is confirmed. The stomach is inspected and palpated for pathology. The duodenum is visualized and palpated. The gallbladder is inspected and palpated for the presence of stones. The liver is palpated bimanually, as is the porta hepatis. The pancreas is inspected through the hepaticogastric ligament and palpated for possible masses. The tail of the pancreas is palpated for possible lymphadenopathy. The small bowel is inspected and palpated from the ligament of Treitz to the ileocecal valve. The small bowel mesentery is inspected and palpated for the presence of lymphadenopathy. The cecum and appendix, ascending, transverse, and descending colon are inspected and palpated. The cul-de-sac and pelvic contents are inspected and palpated. A self-retaining retractor is carefully inserted, while avoiding injury or entrapment of abdominal contents. A self-retaining retractor is carefully inserted, while avoiding injury or entrapment of abdominal contents. The location and extent of

the primary lesions are confirmed. The abdominal contents, to the exclusion of the right colon, are packed away using laparotomy pads and additional retractors are placed for optimal exposure. The right colon is mobilized lateral to medial by incising the line of Toldt. Three 2-3 cm. implanted masses are each individually resected using cautery. During this dissection, the right ureter is identified and a vessel loop is placed for continual identification and protection of the ureter. Additionally, four other 1 cm. nodules are identified in the paracolic gutter. They are each individually resected using the electrocautery. The abdominal cavity is irrigated copiously with antibiotic solution. Hemostasis is obtained. The abdomen is inspected for injury and the presence of any instruments or lap-pads (ie, count is made). The retractor components are removed and accounted for. The abdominal organs are returned to normal anatomical position. The omentum is draped over the abdominal contents. The fascia is closed with running suture. A second instrument, needle, sponge, and lap-pad count is conducted. The subcutaneous tissues are irrigated and approximated and the skin is closed.

Description of Post-Service Work:
Post-service Hospital Work

- Apply Steristrips and sterile dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Instruct nursing staff in care of drains, tubes and other devices. Review post-operative labs. Check chest x-ray to confirm location of NG tube and assess pulmonary status. Discuss procedure and outcome with family in waiting area. Write brief operative note. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Patient is discharged from recovery room.
- Write patient care orders and discuss floor care with nursing staff.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Assess need for antibiotics, order as required. Discontinue as required.
- Monitor and document patient progress: evaluate for sepsis, bowel function; cardiorespiratory function.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Prior to discharge, the pathology is reviewed with the patient.
- Manage nasogastric tube, remove when appropriate and advance diet.
- Obtain oncology consultations.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members, and discharging nurse.
- The patient is discharged when there is return of bowel function, adequate nutrition intake, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-service Office Work

- Examine and talk with patient.
- Monitor healing of incision with appropriate physical examination, including answering questions from patient and family.
- Remove sutures and staples, when appropriate.
- Monitor diet caloric intake by weight. Arrange for dietary consultation as needed.
- Review pathology report in response to family/patient questions.
- Answer patient/family questions.

- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed, as necessary.
- Begin routine surveillance for recurrent tumor. Discuss schedule of patient examination and imaging surveillance.
- Discuss the need for postoperative chemotherapy with patient.
- Discuss the need for postoperative radiotherapy with patient.
- Offer referral to cancer support groups.
- Discuss progress with referring physician(s) (verbal and written).
- Discuss case with oncologist and prepare documents for transmission to that office.
- Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Charles Mabry, MD, FACS Christopher Senkowski, MD, FACS George Hill, MD					
Specialty(s):	ACS					
CPT Code:	49203					
Sample Size:	150	**Resp N:** 18	**Response:** 12.0 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	4.00	**8.00**	10.00	58.00
Survey RVW:		12.00	20.00	**22.23**	25.75	35.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	100.00	**120.00**	146.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**100.0**	99231x **3.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49203	
	Specialty Recommended
Physician Work RVU:	19.69
Pre-Service Evaluation Time:	45.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	15.0
Intra-Service Time:	120.00
Immediate Post Service-Time:	30.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	100.0	99231x 3.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58957	090	26.06	RUC Time

CPT Descriptor Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
44140	090		22.46	RUC Time

CPT Descriptor 1 Colectomy, partial; with anastomosis

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 46.6 %

TIME ESTIMATES (Median)	CPT Code: 49203	Key Reference CPT Code: 58957	Source of Time RUC Time
Median Pre-Service Time	70.00	90.00	
Median Intra-Service Time	120.00	180.00	
Median Immediate Post-service Time	30.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	79.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**420.00**	**552.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.96
Urgency of medical decision making	3.21	3.68
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.38	4.50
Physical effort required	4.17	4.36
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.21	4.29
Outcome depends on the skill and judgment of physician	4.45	4.43

Estimated risk of malpractice suit with poor outcome	4.24	3.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.76	3.86
Intra-Service intensity/complexity	4.17	4.25
Post-Service intensity/complexity	3.45	3.75

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A CPT review of codes 49200 and 49201 arose from a discussion at both the 2nd and 3rd 5-year review processes. As presented in the CPT proposal, the existing codes used to report these services, are amorphous codes that describe a wide group of unrelated procedures. There are no clinical vignettes for 49200 and 49201, since they were Harvard valued and have never been surveyed. An attempt was made to survey these codes for both the 2nd and 3rd 5-year reviews, but difficulties arose in developing clinical vignettes that span procedures common to general surgery, surgical oncology, gynecology, and gynecologic oncology. After two different CPT proposals were reviewed an accepted by CPT, the two codes 49200 and 49201 were deleted and five new codes that describe current practice were developed which require RUC surveys.

For new code 49203, a survey was sent to general surgeons, surgical oncology specialists, and obstetricians/gynecologists. A consensus panel of these specialties reviewed the survey data compared with the reference code and other services performed by these specialties. The median intra-time and length of stay was identical for general surgery compared with all other specialties. The median RVW was also similar. After discussion of the new code and reference codes, the panel noted that the new code requires less total work than the key reference code 58957. The panel also discussed a second key reference, 44140 (Colectomy, partial; with anastomosis), and agreed that the new code was less total work than this code. Given the differences in intra-time and total work, the panel recommends the 25th percentile RVW of 19.69 for the new code (IWPUT=0.087). This value correctly sets this new code slightly less than the reference codes as discussed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49200 or 49201

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty General surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8610
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. To determine national frequency, we used the NCDB yearly average from 2000-2004 for 49200 and 49201 (25,000) and subtracted the national estimates for the new gynecology codes (58957 and 58958) created last year (9250 and 1400 (10,650 total) for a total frequency of 14,350 (25000-10650)). We used the surveyees' performance rate for 49203, 49204 and 49205 to determine the frequency allocation between the three new codes. Using this data, we determine 49203 would be billed 60 percent of the time (14,500 x .60 = 8610), 49204 30 percent of the time (14350 x .30=4305) and 49205 10 percent of the time (14350 x .10= 1435). Because 58957 and 58958 are new codes, we do not have frequency data available. The majority of the gynecology work originally included in 49200 and 49201 will be billed to 58957 and 58958, but some gynecology cases will be billed using 49203 and 49204. Ob-gyn billed 49200 and 48201 12 and 23 percent of the time, respectively. Based on this, our best estimate is that general surgery will bill 49203 80 percent of the time and ob-gyn will bill 49203 20 percent of the time.

Specialty General surgery Frequency 6888 Percentage %

Specialty Ob-Gyn Frequency 1722 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,700 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. To determineMedicare frequency, we used the 2005 Medicare frequency data for 49200 and 49201 (5501) and subtracted the national estimates for the new gynecology codes (58957 and 58958) created last year (750 and 250 (1000 total) for a total frequency of 4501 (5501-1000)). We used the surveyees' performance rate for 49203, 49204 and 49205 to determine the frequency allocation between the three new codes. Using this data, we determine 49203 would be billed 60 percent of the time (4501 x .60 = 2700), 49204 30 percent of the time (4501 x .30=1350) and 49205 10 percent of the time (4501 x .10= 450). Because 58957 and 58958 are new codes, we do not have frequency data available. The majority of the gynecology work originally included in 49200 and 49201 will be billed to 58957 and 58958, but some gynecology cases will be billed using 49203 and 49204. Ob-gyn billed 49200

and 48201 12 and 23 percent of the time, respectively. Based on this, our best estimate is that general surgery will bill 49203 80 percent of the time and ob-gyn will bill 49203 20 percent of the time.

Specialty General surgery Frequency 2160 Percentage %

Specialty Ob-Gyn Frequency 540 Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49204 Tracking Number JJ2 Specialty Society Recommended RVU: **26.00**
Global Period: 090 RUC Recommended RVU: **26.00**

CPT Descriptor: Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1 to 10.0 cm diameter

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 45-year-old female has diarrhea. A CT scan reveals a 7 cm. mesenteric mass adjacent to the mid ileum. The work-up suggests the mass is a neuroendocrine tumor (carcinoid). Two small bowel lesions are seen on an octreotide scan.

Percentage of Survey Respondents who found Vignette to be Typical:

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Write orders for preoperative medications including beta blockers, if indicated.
- Review pre-operative work-up, with particular attention to imaging information and reports.
- Review results of preoperative testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Confirm with nurses and patient that this will be done with an abdominal midline incision and there is no sidedness.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:
Skin incision is made using sharp dissection. Hemostasis is achieved using electrocautery and small ligatures, as necessary. The linea alba is identified and carefully divided. The peritoneum is grasped, elevated, and carefully incised to avoid injury to bowel. The peritoneal cavity is entered under direct vision. Adhesions are cleared by sharp dissection in order to expose all of the abdominal viscera. A visual and manual complete exploration of the abdominal cavity and its contents is carried out. The NG tube is placed and its position is confirmed. The stomach is inspected and palpated for pathology. The duodenum is visualized and palpated. The gallbladder is inspected and palpated for the presence of stones. The liver is palpated bimanually, as is the porta hepatis. The pancreas is inspected through the hepaticogastric ligament and palpated for possible masses. The tail of the pancreas is palpated for possible lymphadenopathy. The small bowel is inspected and palpated from the ligament of Treitz to the ileocecal valve. Two small bowel masses are palpated adjacent to the mass. The small bowel mesentery is inspected and palpated for the presence of lymphadenopathy. The cecum and appendix, ascending, transverse, and descending colon are inspected and palpated. The cul-de-sac and pelvic contents are inspected and palpated. A self-retaining retractor is carefully inserted, while avoiding injury or entrapment of abdominal contents. A self-retaining retractor is carefully inserted, while avoiding injury or entrapment of abdominal

contents. The location and extent of the primary lesion is confirmed. The abdominal contents, to the exclusion of the right colon, are packed away using laparotomy pads and additional retractors are placed for optimal exposure. The right colon is mobilized lateral to medial by incising the line of Toldt. A seven cm. mass is identified in the mesentery adjacent to above mentioned small bowel lesions. It is carefully dissected from the retroperitoneal tissues. The superior mesenteric artery is identified and isolated with vessel loops. Additionally, during this dissection, the right ureter is identified and a vessel loop is placed for continual identification and protection of the ureter. The mass is completely dissected away from the duodenum and mesenteric vessels as well as the ureter. The two small bowel lesions are resected en bloc from the mesentery of the small bowel. The abdominal cavity is irrigated copiously with antibiotic solution. Hemostasis is obtained. The abdomen is inspected for injury and the presence of any instruments or lap-pads (ie, count is made). The retractor components are removed and accounted for. The abdominal organs are returned to normal anatomical position. The omentum is draped over the abdominal contents. The fascia is closed with running suture. A second instrument, needle, sponge, and lap-pad count is conducted. The subcutaneous tissues are irrigated and approximated and the skin is closed.

Description of Post-Service Work:
Post-service Hospital Work

- Apply Steristrips and sterile dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Instruct nursing staff in care of drains, tubes and other devices. Review post-operative labs. Check chest x-ray to confirm location of NG tube and assess pulmonary status. Discuss procedure and outcome with family in waiting area. Write brief operative note. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Patient is discharged from recovery room.
- Write patient care orders and discuss floor care with nursing staff.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Assess need for antibiotics, order as required. Discontinue as required.
- Monitor and document patient progress: evaluate for sepsis, bowel function; cardiorespiratory function.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Prior to discharge, the pathology is reviewed with the patient.
- Manage nasogastric tube, remove when appropriate and advance diet.
- Obtain oncology consultations.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members, and discharging nurse.
- The patient is discharged when there is return of bowel function, adequate nutrition intake, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-service Office Work

- Examine and talk with patient.
- Monitor healing of incision with appropriate physical examination, including answering questions from patient and family.
- Remove sutures and staples, when appropriate.

- Monitor diet caloric intake by weight. Arrange for dietary consultation as needed.
- Review pathology report in response to family/patient questions.
- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed, as necessary.
- Begin routine surveillance for recurrent tumor. Discuss schedule of patient examination and imaging surveillance.
- Discuss the need for postoperative chemotherapy with patient.
- Discuss the need for postoperative radiotherapy with patient.
- Offer referral to cancer support groups.
- Discuss progress with referring physician(s) (verbal and written).
- Discuss case with oncologist and prepare documents for transmission to that office.
- Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Charles Mabry, MD, FACS Christopher Senkowski, MD, FACS George Hill, MD				
Specialty(s):	ACS				
CPT Code:	49204				
Sample Size: 650	**Resp N:** 18	**Response:** 2.7 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**4.00**	5.00	25.00
Survey RVW:	23.00	26.00	**26.50**	30.00	45.00
Pre-Service Evaluation Time:			**58.0**		
Pre-Service Positioning Time:			**8.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	90.00	128.00	**160.00**	180.00	300.00
Immediate Post Service-Time:	**30.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**160.0**	99231x **4.0** 99232x **2.0** 99233x **0.0**			
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**			
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49204		
		Specialty Recommended
Physician Work RVU:		26.00
Pre-Service Evaluation Time:		58.0
Pre-Service Positioning Time:		8.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		160.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	140.0	99231x 5.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58957	090	26.06	RUC Time

CPT Descriptor Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
44140	090		22.46	RUC Time

CPT Descriptor 1 Colectomy, partial; with anastomosis

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 39.5 %

TIME ESTIMATES (Median)	CPT Code: 49204	Key Reference CPT Code: 58957	Source of Time RUC Time
Median Pre-Service Time	81.00	90.00	
Median Intra-Service Time	160.00	180.00	
Median Immediate Post-service Time	30.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	140.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	79.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**511.00**	**552.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.07	4.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	4.13
Urgency of medical decision making	3.60	3.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.47	4.53
Physical effort required	4.47	4.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.27	4.40
Outcome depends on the skill and judgment of physician	4.40	4.27

Estimated risk of malpractice suit with poor outcome	3.93	3.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.93	4.07
Intra-Service intensity/complexity	4.56	4.40
Post-Service intensity/complexity	3.80	4.13

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A CPT review of codes 49200 and 49201 arose from a discussion at both the 2nd and 3rd 5-year review processes. As presented in the CPT proposal, the existing codes used to report these services, are amorphous codes that describe a wide group of unrelated procedures. There are no clinical vignettes for 49200 and 49201, since they were Harvard valued and have never been surveyed. An attempt was made to survey these codes for both the 2nd and 3rd 5-year reviews, but difficulties arose in developing clinical vignettes that span procedures common to general surgery, surgical oncology, gynecology, and gynecologic oncology. After two different CPT proposals were reviewed an accepted by CPT, the two codes 49200 and 49201 were deleted and five new codes that describe current practice were developed which require RUC surveys.

For new code 49204, a survey was sent to general surgeons, surgical oncology specialists, and obstetricians/gynecologists. A consensus panel of these specialties reviewed the survey data compared with the reference code and other services performed by these specialties. The median intra-time was 5 minutes less for general surgery compared with all other specialties. The median RVW was slightly greater for general surgery compared with all other specialties. After discussion of the new code and reference codes, the panel noted that the new code was very similar in total work to the key reference code 58957, with slightly less intra-operative time, but greater length of stay. The panel also discussed a second key reference, 44140 (Colectomy, partial; with anastomosis), and agreed that the new code was greater total work than this code. Given this discussion, the panel recommends the median RVW of 26.00 for the new code (IWPUT=0.088). This value is correctly similar to the key reference code 58957 and greater than 44140.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49200 or 49201

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty General surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4305
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. To determine national frequency, we used the NCDB yearly average from 2000-2004 for 49200 and 49201 (25,000) and subtracted the national estimates for the new gynecology codes (58957 and 58958) created last year (9250 and 1400 (10,650 total) for a total frequency of 14,350 (25000-10650)). We used the surveyees' performance rate for 49203, 49204 and 49205 to determine the frequency allocation between the three new codes. Using this data, we determine 49203 would be billed 60 percent of the time (14,500 x .60 = 8610), 49204 30 percent of the time (14350 x .30=4305) and 49205 10 percent of the time (14350 x .10= 1435). Because 58957 and 58958 are new codes, we do not have frequency data available. The majority of the gynecology work originally included in 49200 and 49201 will be billed to 58957 and 58958, but some gynecology cases will be billed using 49203 and 49204. Ob-gyn billed 49200 and 48201 12 and 23 percent of the time, respectively. Based on this, our best estimate is that general surgery will bill 49203 90 percent of the time and ob-gyn will bill 49203 10 percent of the time.

Specialty General surgery Frequency 3874 Percentage %

Specialty Ob-Gyn Frequency 430 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,350 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. To determineMedicare frequency, we used the 2005 Medicare frequency data for 49200 and 49201 (5501) and subtracted the national estimates for the new gynecology codes (58957 and 58958) created last year (750 and 250 (1000 total) for a total frequency of 4501 (5501-1000)). We used the surveyees' performance rate for 49203, 49204 and 49205 to determine the frequency allocation between the three new codes. Using this data, we determine 49203 would be billed 60 percent of the time (4501 x .60 = 2700), 49204 30 percent of the time (4501 x .30=1350) and 49205 10 percent of the time (4501 x .10= 450). Because 58957 and 58958 are new codes, we

do not have frequency data available. The majority of the gynecology work originally included in 49200 and 49201 will be billed to 58957 and 58958, but some gynecology cases will be billed using 49203 and 49204. Ob-gyn billed 49200 and 48201 12 and 23 percent of the time, respectively. Based on this, our best estimate is that general surgery will bill 49203 90 percent of the time and ob-gyn will bill 49203 10 percent of the time.

Specialty General surgery Frequency 1215 Percentage %

Specialty Ob-Gyn Frequency 135 Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49205 Tracking Number JJ3 Specialty Society Recommended RVU: **30.00**
Global Period: 090 RUC Recommended RVU: **30.00**

CPT Descriptor: Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 55-year-old male is evaluated for four months of vague abdominal pain. A CT scan reveals a 25 cm left retroperitoneal mass. Biopsy reveals a liposarcoma. The mass has displaced the left colon, left kidney, and the pancreas superiorly. There is no metastatic disease.

Percentage of Survey Respondents who found Vignette to be Typical:

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Write orders for preoperative medications including beta blockers, if indicated.
- Review pre-operative work-up, with particular attention to imaging information and reports.
- Review results of preoperative testing (lab, EKG, chest x-ray, availability of blood products).
- Meet with patient and family to review planned procedure and post-operative management.
- Mark site and side of proposed skin incision and confirm with patient.
- Review and obtain informed consent, including witness.
- Review length and type of anesthesia with anesthesiologist.
- Verify that all required instruments and supplies are available.
- Assist in transfer of patient from gurney to operating table.
- Monitor/assist with positioning of patient.
- Assist anesthesia team with line placement and induction of anesthesia and intubation.
- Indicate areas of skin to be prepped and mark surgical incisions.
- Scrub and gown.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:
Skin incision is made using sharp dissection. Hemostasis is achieved using electrocautery and small ligatures, as necessary. The linea alba is identified and carefully divided. The peritoneum is grasped, elevated, and carefully incised to avoid injury to bowel. The peritoneal cavity is entered under direct vision. Adhesions are cleared by sharp dissection in order to expose all of the abdominal viscera. A visual and manual complete exploration of the abdominal cavity and its contents is carried out. The NG tube is placed and its position is confirmed. The stomach is inspected and palpated for pathology. The duodenum is visualized and palpated. The gallbladder is inspected and palpated for the presence of stones. The liver is palpated bimanually, as is the porta hepatis. The pancreas is inspected through the hepaticogastric ligament and palpated for possible masses. The tail of the pancreas is palpated for possible lymphadenopathy. The small bowel is inspected and palpated from the ligament of Treitz to the ileocecal valve. The small bowel mesentery is inspected and palpated for the presence of lymphadenopathy. The cecum and appendix, ascending, transverse, and descending colon are inspected and palpated. The cul-de-sac and pelvic contents are inspected and palpated. A self-retaining retractor is carefully inserted, while avoiding injury or entrapment of abdominal contents. A self-retaining retractor is carefully inserted, while avoiding injury or entrapment of abdominal contents. Examination reveals a

massive 25 cm. tumor emanating from the left retroperitoneum. The left colon is mobilized as is the splenic flexure of the colon. The pancreas must be elevated anteriorly and superiorly off of the upper portion of the mass. Additionally, the left kidney is dissected from the mass with care taken to avoid injury to the renal vessels. The mass encroaches upon the aorta for a length of 10 cm. the mass is carefully dissected away from the aorta, carefully ligating bridging tumor vessels and lumbar vessels. The left ureter is isolated and protected with vessel loops. It is protected throughout the procedure and is not resected. The final dense attachments between the mass and the retroperitoneal muscles are carefully divided with electrocautery and ultrasonic or harmonic dissectors. The mass is completely resected. The abdominal cavity is irrigated copiously with antibiotic solution. Hemostasis is obtained. The abdomen is inspected for injury and the presence of any instruments or lap-pads (ie, count is made). The retractor components are removed and accounted for. The abdominal organs are returned to normal anatomical position. The omentum is draped over the abdominal contents. The fascia is closed with running suture. A second instrument, needle, sponge, and lap-pad count is conducted. The subcutaneous tissues are irrigated and approximated and the skin is closed.

Description of Post-Service Work:
Post-service Hospital Work

- Apply Steristrips and sterile dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Instruct nursing staff in care of drains, tubes and other devices. Review post-operative labs. Check chest x-ray to confirm location of NG tube and assess pulmonary status. Discuss procedure and outcome with family in waiting area. Write brief operative note. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Patient is discharged from recovery room.
- Write patient care orders and discuss floor care with nursing staff.
- Examine patient, including reviewing vital signs and confirming as necessary.
- Auscultate heart, lungs, and abdomen for bowel sounds.
- Manage dressings to wounds daily, monitoring status of incision, looking for signs of infection.
- Continue prophylaxis for DVT. Monitor daily for adequacy.
- Assess need for beta-blockers, order as required.
- Assess need for antibiotics, order as required. Discontinue as required.
- Monitor and document patient progress: evaluate for sepsis, bowel function; cardiorespiratory function.
- Assess pain scores and adequacy of analgesia.
- Monitor fluid and electrolyte status and renal function.
- Review nursing/other staff patient chart notes.
- Write orders for labs, films, medications, diet, and patient activity.
- Chart patient progress notes, daily.
- Answer patient and family questions. Answer nursing/other staff questions.
- Prior to discharge, the pathology is reviewed with the patient.
- Manage nasogastric tube, remove when appropriate and advance diet.
- Obtain oncology consultations.
- Write prescriptions for medications needed post-discharge.
- Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members, and discharging nurse.
- The patient is discharged when there is return of bowel function, adequate nutrition intake, and adequate pain control with oral analgesics.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-service Office Work

- Examine and talk with patient.
- Monitor healing of incision with appropriate physical examination, including answering questions from patient and family.
- Remove sutures and staples, when appropriate.
- Monitor diet caloric intake by weight. Arrange for dietary consultation as needed.
- Review pathology report in response to family/patient questions.

- Answer patient/family questions.
- Write medication prescriptions.
- Post discharge labs/films are ordered and reviewed, as necessary.
- Begin routine surveillance for recurrent tumor. Discuss schedule of patient examination and imaging surveillance.
- Discuss the need for postoperative chemotherapy with patient.
- Discuss the need for postoperative radiotherapy with patient.
- Offer referral to cancer support groups.
- Discuss progress with referring physician(s) (verbal and written).
- Discuss case with oncologist and prepare documents for transmission to that office.
- Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Charles Mabry, MD, FACS Christopher Senkowski, MD, FACS					
Specialty(s):	ACS					
CPT Code:	49205					
Sample Size:	150	**Resp N:**	18	**Response:** 12.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**1.00**	4.00	8.00
Survey RVW:		27.00	29.00	**30.00**	38.25	68.00
Pre-Service Evaluation Time:				**50.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		120.00	185.00	**225.00**	240.00	360.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**215.0**	99231x **4.0** 99232x **2.0** 99233x **1.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49205	
	Specialty Recommended
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	
Immediate Post Service-Time:	____

Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x	99232x	99233x		
Discharge Day Mgmt:	**0.0**	99238x	99239x			
Office time/visit(s):	**0.0**	99211x	12x	13x	14x	15x
Prolonged Services:	**0.0**	99354x	55x	56x	57x	

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43633	090	33.01	RUC Time

CPT Descriptor Gastrectomy, partial, distal; with Roux-en-Y reconstruction

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 22.2 %

TIME ESTIMATES (Median)

	CPT Code: 49205	Key Reference CPT Code: 43633	Source of Time RUC Time
Median Pre-Service Time	75.00	60.00	
Median Intra-Service Time	225.00	240.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	215.0	310.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**645.00**	**740.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.25
Urgency of medical decision making	4.75	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.50
Physical effort required	5.00	4.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.75	4.75
Outcome depends on the skill and judgment of physician	4.50	4.50
Estimated risk of malpractice suit with poor outcome	4.00	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	5.00	3.75
Intra-Service intensity/complexity	5.00	4.50
Post-Service intensity/complexity	4.00	3.75

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A CPT review of codes 49200 and 49201 arose from a discussion at both the 2nd and 3rd 5-year review processes. As presented in the CPT proposal, the existing codes used to report these services, are amorphous codes that describe a wide group of unrelated procedures. There are no clinical vignettes for 49200 and 49201, since they were Harvard valued and have never been surveyed. An attempt was made to survey these codes for both the 2nd and 3rd 5-year reviews, but difficulties arose in developing clinical vignettes that span procedures common to general surgery, surgical oncology, gynecology, and gynecologic oncology. After two different CPT proposals were reviewed an accepted by CPT, the two codes 49200 and 49201 were deleted and five new codes that describe current practice were developed which require RUC surveys.

For new code 49205, a survey was sent to general surgeons and surgical oncology specialists. A consensus panel of these specialties reviewed the survey data compared with the reference code and other services performed by these specialties. The survey response was low, but this code is not expected to be performed frequently. The median 12 month experience of the responders was one. After discussion of the new code and reference codes, the panel noted that the new code requires less total work than the key reference code 43633 (Gastrectomy, partial, distal; with Roux-en-Y reconstruction). The panel also discussed a second key reference, 58957 (Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;), and agreed that the new code required significantly more work than this code. Given the differences relative to these two codes, the panel recommends the median RVW of 30.00 for the new code (IWPUT=0.073). This value correctly sets this new code between the reference codes as discussed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49200 or 49201

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty General surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1435
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. To determine national frequency, we used the NCDB yearly average from 2000-2004 for 49200 and 49201 (25,000) and subtracted the national estimates for the new gynecology codes (58957 and 58958) created last year (9250 and 1400 (10,650 total) for a total frequency of 14,350 (25000-10650)). We used the surveyees' performance rate for 49203, 49204 and 49205 to determine the frequency allocation between the three new codes. Using this data, we determine 49203 would be billed 60 percent of the time (14,500 x .60 = 8610), 49204 30 percent of the time (14350 x .30=4305) and 49205 10 percent of the time (14350 x .10= 1435). Because 58957 and 58958 are new codes, we do not have frequency data available. The majority of the gynecology work originally included in 49200 and 49201 will be billed to 58957 and 58958, but some gynecology cases will be billed using 49203 and 49204. Ob-gyn billed 49200 and 48201 12 and 23 percent of the time, respectively. Based on this, our best estimate is that general surgery will bill 49203 95 percent of the time and ob-gyn will bill 49203 5 percent of the time.

Specialty General surgery Frequency 1363 Percentage %

Specialty Ob-gyn Frequency 71 Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 450
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. To determineMedicare frequency, we used the 2005 Medicare frequency data for 49200 and 49201 (5501) and subtracted the national estimates for the new gynecology codes (58957 and 58958) created last year (750 and 250 (1000 total) for a total frequency of 4501 (5501-1000)). We used the surveyees' performance rate for 49203, 49204 and 49205 to determine the frequency allocation between the three new codes. Using this data, we determine 49203 would be billed 60 percent of the time (4501 x .60 = 2700), 49204 30 percent of the time (4501 x .30=1350) and 49205 10 percent of the time (4501 x .10= 450). Because 58957 and 58958 are new codes, we do not have frequency data available. The majority of the gynecology work originally included in 49200 and 49201 will be billed to 58957 and 58958, but some gynecology cases will be billed using 49203 and 49204. Ob-gyn billed 49200 and 48201 12 and 23 percent of the time, respectively. Based on this, our best estimate is that general surgery will bill 49203 95 percent of the time and ob-gyn will bill 49203 5 percent of the time.

Specialty General surgery	Frequency 427	Percentage	%
Specialty Ob-gyn	Frequency 22	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less

49204 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1 to 10.0 cm diameter

49205 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel of surgeons representing general surgery and obstetrics/gynocology reviewed the practice expense details for the survey codes relative to other facility-only 90-day global services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes has been applied for these inpatient procedures for discharge day management services.

Post-Service Clinical Labor Activities:

The standard times have been applied for post-service clinical labor time.

	A	B	C	D	E	F	G	H	I
1				49203		49204		49205	
2	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee			Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or		Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or		Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or	
3	LOCATION	Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			N/A	90	N/A	90	N/A	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	171	N/A	171	N/A	171
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	12	N/A	12	N/A	12
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	99	N/A	99	N/A	99
9	[illegible]								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
17	**End: When patient enters office/facility for surgery/procedure**								
18	[illegible]								
19	**Start: When patient enters office/facility for surgery/procedure**								
39	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D	RN/LPN/MTA		12		12		12
40	Other Clinical Activity (please specify)								
41	**End: Patient leaves office/FACILITY**								
42	[illegible]								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes		16						
48	99212 27 minutes	L037D	27		1		1		1
49	99213 36 minutes	L037D	36		2		2		2
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
53									
54	*Total Office Visit Time*			0	99	0	99	0	99
55	Other Activity (please specify)								
56	**End: with last office visit before end of global period**								
57	[illegible]								
58	pack, minimum multi-specialty visit	SA048	pack		3		3		3
59	pack, post-op incision care (suture)	SA054	kit		1		1		1
60									
61									
62									
63	[illegible]								
64	table, power	EF031			99		99		99
65	light, exam	EQ168			99		99		99

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

G-, J-, G-J and C-Tube Procedures

The CPT Editorial Panel created nine new codes and revised one current code to describe the array of percutaneous gastrostomy, jejunostomy, gastro-jejunostomy or cecostomy tube procedures and services including initial placement, conversion, replacement and removal, as well as mechanical removal of obstructive material and injection of contrast for radiological evaluation of a tube.

The RUC reviewed 49440-49465 and 43760. The RUC recognized that the survey response rates were low, ranging from 15-20 respondents for 49440-49465. The RUC noted that these procedures are frequently performed and the small number of respondents did not adequately represent these services as performed. **The RUC recommends that the following work RVUs as interim values until the RUC next meeting after the specialty societies have resurveyed and are able to present representative recommendations.** Additionally, code 43760 had a sufficient response rate of 40 respondents, however, since the recommended value is linked to 49450 and the specialty society determined that it should be resurveyed as well.

1151

49440 *Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49440 and compared this service to the key reference code 36558 *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (Work RVU=4.81). The RUC determined that the physician time required to perform 49440 was similar to the reference service. However, the RUC determined that a discharge day management visit was not performed and the associated work RVUs should be extracted. The RUC determined that extracting 1.28 RVUs of the discharge day management (99238) from the survey median RVU of 4.60, would place this service in the proper rank order among other services within this family and across specialties (4.60-1.28=3.32 Work RVU). The RUC also compared this service to codes 44365 *Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* (Work RVU=3.31) and 45915 *Removal of fecal impaction or foreign body (separate procedure) under anesthesia* (Work RVU=3.16) and determined that the recommended work RVU places code 49440 in the proper rank order. **The RUC recommends an interim work relative value of 3.32 for code 49440.**

49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49441 and determined that the survey respondents overestimated the pre-service scrub, dress, and wait time, therefore the RUC reduced this time to 10 minutes. The RUC also determined that a discharge day management visit was not performed and the associated work RVUs should be extracted. The RUC determined that extracting 1.28 RVUs of the discharge day management (99238) from the survey median RVU of 7.00 would place this service in the proper rank order among other services within this family and across specialties

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(7.00-1.28=5.72 Work RVU). The RUC also compared this service to codes 45382 *Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (Work RVU=5.68) and 49421 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent* (Work RVU=5.87) and determined that the recommended work RVU places code 49441 in the proper rank order. **The RUC recommends an interim work relative value of 5.72 for code 49441.**

49442 *Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49442 and determined that the specialty recommendation of the 75% percentile survey work RVU supported by a building block methodology was not representative of this procedure. The median survey work RVU of 5.15 was used as a starting point for valuing 49442. The RUC determined that a discharge day management visit was not performed and the associated work RVUs should be extracted. In addition, the RUC and specialty societies agreed only one hospital post-operative visit (99231) was typical rather than two, as indicated from the survey results. The RUC determined that extracting 1.28 RVUs of the discharge day management (99238) from the survey median RVU of 5.15, would place this service in the proper rank order among other services within this family and across specialties (5.15-1.28=3.87 Work RVU). The RUC also compared this service to code 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (Work RVU = 3.99) and determined that in relation to this service, code 49442 would be properly valued at 3.87 RVUs. **The RUC recommends an interim work relative value of 3.87 for code 49442.**

1152

49446 *Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49446 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49446:
45345 *Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)* (Work RVU = 2.92)
31623 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with brushing or protected brushings* (Work RVU = 2.88)
52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (Work RVU = 3.02)

The RUC recommends an interim relative work value of 2.94 for code 484X4.

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49450 *Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49450 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49450:
36584 *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access* (Work RVU = 1.20)

The RUC recommends an interim relative work value of 1.14 for code 49450.

1153

49451 *Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49451 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties The RUC reviewed the following services to ensure proper rank order placement of 49451:
91122 *Anorectal manometry* (Work RVU = 1.77)
57456 *Colposcopy of the cervix including upper/adjacent vagina; with endocervical* curettage (Work RVU = 1.85)

The RUC recommends an interim relative work value of 1.82 for code 49451.

49452 *Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49452 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on

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a building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49452:
57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (Work RVU = 2.83)

The RUC recommends an interim relative work value of 2.81 for code 49452.

49460 *Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report*
The RUC reviewed the survey data for 49460 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on the building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49460:
46608 *Anoscopy; with removal of foreign body* (Work RVU = 1.51)
62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (Work RVU = 1.54)

The RUC recommends an interim relative work value of 1.51 for code 49460.

49465 *Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report*
The RUC reviewed the survey data for 49465 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on the building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49465:
36598 *Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report* (Work RVU = 0.74)

The RUC recommends an interim relative work value of 0.62 for code 49465.

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43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*
The RUC reviewed the survey results for 43760 and agreed with the specialty societies the pre-service time did not reflect that this service is typically performed in the outpatient emergency room setting. The RUC decreased the pre-service physician time to reflect the typical site of service. The physician work involved in 43760 was compared to new code 49450 with the revised recommended work RVU of 1.14, which includes fluoroscopic guidance and image documentation. The RUC determined that the surveyed median of 1.15 RVUs should be reduced to reflect the lack of fluoroscopic guidance and image documentation, but also that the service be relative to other cross specialty services. The RUC reviewed the following codes and believed the overall physician work was similar in intensity and complexity, but required less physician time.
99282 *Emergency department visit for the evaluation and management of a patient* (Work RVU = 0.88)
99213 *Office or other outpatient visit for the evaluation and management of an established patient* (Work RVU = 0.92)

The RUC determined that a reduction of 0.24 work RVUs from the survey median of 1.14 reflects the lack of fluoroscopic guidance and documentation and places the service in the correct rank order with other services on the physician payment schedule (1.14-0.24=0.90). In addition, the specialty survey 25th percentile results indicated a work RVU of 0.95. **The RUC recommends an interim work RVU of 0.90 for code 43760.**

Conscious Sedation
The RUC determined that conscious sedation was only inherent in codes 49440, 49441, 49442 and 49446 but not for any other code in this family. The facilitation committee recommends no conscious sedation components in the practice expense of codes 49450, 49451, 49452, 49460, and 49465.

Practice Expense
The RUC reviewed and accepted the direct practice expense inputs as modified (eg, remove discharge day management).

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Adjustments to Time and RVUs

CPT Code	Tracking Code	Original Specialty Rec	Starting Point RVU	RVUs Adjustment Post Operative Visits	Time Adjustment-Eval Time	Time Adjustment-Positioning Time	Time Adjustment -Scrub Dress Wait	Time Adjustment - Immediate Post	RVU Adjustment from Pre and Immed Post	Final Work Recommendation
49440	KK1	4.60	4.60	-1.28	0	0	0	0	0.0000	3.32
49441	KK2	7.00	7.00	-1.28	0	0	0	0	0.0000	5.72
49442	KK3	6.58	5.15	-1.28	0	0	0	0	0.0000	3.87
49446	KK4	3.50	3.50	0.00	-20	1	-3	-5	-0.5619	2.94
49450	KK5	1.50	1.50	0.00	-15	0	-3	0	-0.3603	1.14
49451	KK6	2.20	2.20	0.00	-15	1	-3	-2	-0.3827	1.82
49452	KK7	3.30	3.30	0.00	-20	0	-3	-1	-0.4947	2.81
49460	KK8	2.00	2.00	0.00	-15	-3	-3	-3	-0.4947	1.51
49465	KK9	0.76	0.76	0.00	-5	0	-3	0	-0.1363	0.62
43760	KK10	1.10	1.10	0.00	-5	0	-3	0	0	0.90

Final Physician Time

CPT Code	Tracking Code	Pre Eval Time	Pre Positioning Time	Pre Scrub Dress Wait	Intra Service Time	Immediate Post	Post Op Visit Time	Total Physician Time	Final Work Recommendation
49440	KK1	35	10	10	30	15	36	136	**3.32**
49441	KK2	45	10	12	60	15	36	178	**5.72**
49442	KK3	43	15	12	30	15	43	158	**3.87**
49446	KK4	10	7	7	30	10	0	64	**2.94**
49450	KK5	10	7	7	15	10	0	49	**1.14**
49451	KK6	10	7	7	20	10	0	54	**1.82**
49452	KK7	10	7	7	28	10	0	62	**2.81**
49460	KK8	10	7	7	15	10	0	49	**1.51**
49465	KK9	10	7	7	8	10	0	42	**0.62**
43760	KK10	10	5	2	10	5	0	32	**0.90**

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Do not additionally report 43752 for placement of a nasogastric (NG) or oro-gastric (OG) tube to insufflate the stomach prior to percutaneous gastrointestinal tube placement. NG or OG tube placement is considered part of the procedure in this family of codes.				
⊙●49440	KK1	Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report (For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 49446 in addition to 49440)	010	3.32 (Interim Recommendation)
⊙●49441	KK2	Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report (For conversion of gastrostomy tube to gastro-jejunostomy tube, use 49446)	010	5.72 (Interim Recommendation)
⊙●49442	KK3	Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	010	3.87 (Interim Recommendation)
Conversion				
⊙●49446	KK4	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report (For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 49440 in addition to 49446)	000	2.94 (Interim Recommendation)
Replacement If an existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube is removed and a new tube is placed via a separate percutaneous access site, the placement of the new tube is not considered a replacement and would be coded using the appropriate initial placement code, see 49440-49442.				
●49450	KK5	Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	000	1.14 (Interim Recommendation)
●49451	KK6	Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	000	1.82 (Interim Recommendation)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●49452	KK7	Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	000	2.81 (Interim Recommendation)
Mechanical Removal of Obstructive Material				
●49460	KK8	Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report (Do not report code 49460 in conjunction with codes 49450-49452, 49465)	000	1.51 (Interim Recommendation)
Other				
●49465	KK9	Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report (Do not report code 49465 in conjunction with codes 49440-49460)	000	0.62 (Interim Recommendation)
Surgery **Musculoskeletal System** **General** **Introduction or Removal**				
20501		Injection of sinus tract; diagnostic (sinogram) (For contrast injection(s) and radiological assessment of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube including fluoroscopic imaging guidance, use 49465)	000	0.76 (No Change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Digestive System Esophagus Endoscopy				
43235		Upper gastrointestional endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	2.39 (No Change)
43246		with directed placement of percutaneous gastrostomy tube (For non-endoscopic percutaneous placement of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, see 49440-49465, 43750) ~~(For radiological supervision and interpretation, use 74350)~~	000	4.32 (No Change)
Surgery Digestive System Stomach Introduction				
KK10	D 43750	~~Percutaneous placement of gastrostomy tube, percutaneous, without imaging or endoscopic guidance~~ ~~(For radiological supervision and interpretation, use 74350)~~ ~~(To report fluoroscopically guided gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube placement, see 49440-49446)~~	010	N/A
	43752	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (For percutaneous placement of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, see 49440-49442)	000	0.81 (No Change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
KK11	▲43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance (To report fluoroscopically-guided gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube services, see 49450-49465) (For endoscopic placement of gastrostomy tube, use 43246) ~~(For radiological supervision and interpretation, use 75894)~~	000	0.90 (Interim Recommendation)
Surgery **Digestive System** **Enterostomy-External Fistulization of Intestines**				
44300		Enterostomy or cecostomy, tube (eg, for decompression or feeding) (separate procedure) (For percutaneous placement of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube including fluoroscopic imaging guidance, see 49440-49442)	090	13.65 (No Change)
Radiology **Diagnostic Radiology (Diagnostic Imaging)** **Gastrointestinal Tract**				
D 74350		~~Percutaneous placement of gastrostomy tube, radiological supervision and interpretation~~ (74350 has been deleted. To report, gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube placement, see 49440-49446)	XXX	N/A
Transcatheter Procedures				
▲75984		Change of percutaneous tube or drainage catheter with contrast monitoring (eg, ~~gastrointestinal system,~~ genitourinary system, abscess), radiological supervision and interpretation	XXX	0.72 (No Change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For percutaneous replacement of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube including fluoroscopic imaging guidance, see 49450-49452)		
Other Procedures				
76080		Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation (For contrast injection(s) and radiological assessment of gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic)tube including fluoroscopic imaging guidance, see 49465)	XXX	0.54 (No Change)

1161

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49440 Tracking Number KK1 Specialty Society Recommended RVU: **4.60**
Global Period: 010 RUC Recommended RVU: **3.32**

CPT Descriptor: Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report
(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 494X4 in addition to 494X1)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 76 year old male has suffered a recent cerebral vascular accident (CVA) with ongoing issues of dysphagia and risk of aspiration pneumonia. A gastrostomy tube is required to provide adequate enteral nutrition.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Reviews recent CT or US of the abdomen (separately reportable) is performed to confirm an acceptable percutenous window.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Ensures EKG amd hemodynamic monitors are in place and functioning.
-Imaging of the epigastrium is performed to identify interposed bowel.
-Applies topical anesthesia to the selected entry site and a naso-/oro-gastric tube is placed.with position confirmed by imaging.
-Adminstered Glucagon and the stomach is insufflated with air.
-Performs sterile prep of the stomach wall and then percutaneously punctures the wall using fluoroscopic guidance.
-Performs gastropexy with 1-3 fastners; securing the stomach to the abdominal wall.
-Introduces a Seldinger needle into the stomach and passes a wire, allowing serial dilatation.

-Introduces a peel-away sheath through which a 12-22 Fr. gastrostomy tube is placed.
-Secures the retention device internally with the tube secured to the skin externally.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices and patency of the stomach..
-Places the system to ensure gravity drainage and applies a sterile dressing.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for abdominal complications.
-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of G-tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD		
Specialty(s):	Interventional Radiology & Radiology		
CPT Code:	49440		
Sample Size: 375	**Resp N:** 17	**Response:** 4.5 %	
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	12.00	**20.00**	25.00	200.00
Survey RVW:	3.10	4.18	**4.60**	5.20	6.95
Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	20.00	30.00	**30.00**	52.50	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**16.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49440	
	Specialty Recommended
Physician Work RVU:	**4.60**
Pre-Service Evaluation Time:	**35.0**
Pre-Service Positioning Time:	**10.0**
Pre-Service Scrub, Dress, Wait Time:	**10.0**
Intra-Service Time:	**30.00**

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**16.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36558	010	4.81	**RUC Time**

CPT Descriptor Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 41.1 %

TIME ESTIMATES (Median)	CPT Code: 49440	Key Reference CPT Code: 36558	Source of Time RUC Time
Median Pre-Service Time	55.00	36.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	16.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**136.00**	**116.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.29	2.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.40
Urgency of medical decision making	1.86	1.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.71	3.00
Physical effort required	2.57	2.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.14	3.00
Outcome depends on the skill and judgment of physician	3.00	2.80

Estimated risk of malpractice suit with poor outcome	3.14	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.14	2.20
Intra-Service intensity/complexity	3.43	3.00
Post-Service intensity/complexity	2.57	2.40

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. IWPUT was calculated, as follows:

Pre-service RVU = 1.089 = 0.0224*(35+10) + (0.0081*10)

Post-service RVU = 2.826 = (0.0224*15) + 0.76 + 1.28 + 0.45

MEDIAN RECOMMENDED RVU = 4.60

Intra-service RVU = 0.685

IWPUT = .022833 = 0.685/30

Per survey, typical E&M Visits:

In patient	99231 – 1	Physician Work RVUs	0.76
Discharge Day Mgmt	99238 – 1	Physician Work RVUs	1.28
Office Visit	99212 – 1	Physician Work RVUs	0.45

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43750 and 74350

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 20790
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 43750 was previously used to report G and J tube services (X1, X2, X5, X6, X7), which will now be reported using more specific codes. Medicare utilization for code 43750 for 2004 was 32754. An estimate of 60% of services reported using code 43750 are believed to be G-tube placement services that will now be reported using 494X1. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiving these services is believed to be about 5% above that of Medicare. Per 2004 Medicare data, Diagnostic Radiology & Intervenitonal Radiology provide 32.63% of these services, General Surgery provides 40% and Gastroenterology provides 15%, the balance is provided by various other specialties.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 6784 Percentage 32.63 %

Specialty General Surgery Frequency 8316 Percentage 40.00 %

Specialty Gatroenterology Frequency 3119 Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 19,800 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 43750 was previously used to report G and J tube services (X1, X2, X5, X6, X7), which will now be reported using more specific codes. Medicare utilization for code 43750 for 2004 was 32754. An estimate of 60% of services reported using code 43750 are believed to be G-tube placement services that will now be reported using 494X1. Per 2004 Medicare data, Diagnostic Radiology & Intervenitonal Radiology provide 32.63% of these services, General Surgery provides 40% and Gastroenterology provides 15%, the balance is provided by various other specialties.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 6461 Percentage 32.63 %

Specialty General Surgery Frequency 7920 Percentage 40.00 %

Specialty Gastroenterology Frequency 2970 Percentage 15.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 45915 similar work RVU and physician time involved.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49441 Tracking Number KK2 Specialty Society Recommended RVU: **7.00**
Global Period: 010 RUC Recommended RVU: **5.52**

CPT Descriptor: Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report
(For conversion of gastrostomy tube to gastro-jejunostomy tube, use 494X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 38 year old quadriplegic female needing enteral nutrition. The patient has a history of aspiration pneumonia and gastro-esophageal reflux. Consultation is made for percutaneous placement of a jejunal feeding tube, which will provide longer-term access than the currently indwelling naso-duodenal feeding tube.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Reviews recent CT or US of the abdomen (separately reportable) is performed to confirm an acceptable percutenous window.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Ensures EKG amd hemodynamic monitors are in place and functioning.
-Performs sterile prep and drapes the left upper quadrant of the abdomen.
-Inflates the small intestine using medical grade air through the existing duodenal feeding tube.
-Injects contrast into the duodenal feeding tube.
-Applies topical anesthesia to the selected entry site.
-Uses fluoroscopic guidance to localize and directly puncture the jejunum.
-Performs jejunopexy with 2 fastners; securing the jejunum to the anterior abdominal wall.
-Uses fluoroscopic guidance and co-axial technique to access the jejunal segmant and sequentially dilate the track.

-Introduces a peel-away sheath through which a 18 Fr. jejunostomy tube is placed.
-Removes the peel away sheath and secures the retention device and cutaneous cuff.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices and patency of the small intestine.
-Injects contrast to confirm final tube placement and applies a sterile dressing.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for intra-abdominal complications.
-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of J-tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD					
Specialty(s):	Interventional Radiology & Radiology					
CPT Code:	49441					
Sample Size:	375	**Resp N:** 16	**Response:** 4.2 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	3.00	**5.00**	16.00	50.00
Survey RVW:		3.80	4.50	**7.00**	7.81	9.20
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**12.0**		
Intra-Service Time:		40.00	45.00	**60.00**	75.00	90.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**16.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49441	
	Specialty Recommended
Physician Work RVU:	**7.00**
Pre-Service Evaluation Time:	**45.0**
Pre-Service Positioning Time:	**10.0**
Pre-Service Scrub, Dress, Wait Time:	**12.0**
Intra-Service Time:	**60.00**

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**16.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49041	000	3.99	**RUC Time**

CPT Descriptor Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source	-

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 43.7 %

TIME ESTIMATES (Median)

	CPT Code: 49441	Key Reference CPT Code: 49041	Source of Time RUC Time
Median Pre-Service Time	67.00	38.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**178.00**	**128.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.00
Urgency of medical decision making	2.50	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	3.33
Physical effort required	3.75	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.00
Outcome depends on the skill and judgment of physician	5.00	3.33
Estimated risk of malpractice suit with poor outcome	3.25	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.33
Intra-Service intensity/complexity	4.75	3.00
Post-Service intensity/complexity	3.00	2.67

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The workgroup supports the survey median recommended physician RVU of 7.00, which results in an IWPUT of 0.0474; calculated, as follows:

Pre-service RVU = 1.3292 = 0.0224*(45+10) + (0.0081*12)

Post-service RVU = 2.826 = (0.0224*15) + 0.76 + 1.28 + 0.45

MEDIAN RECOMMENDED RVU = 7.00

Intra-service RVU = 2.8448

IWPUT = 0.0474 = 2.8448/60

Per survey, typical E&M visits:

In patient	99231 – 1	Physician Work RVUs	0.76
Discharge Day Mgmt	99238 – 1	Physician Work RVUs	1.28
Office Visit	99212 – 1	Physician Work RVUs	0.45

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43750, 43761 and 74355 (74350 if dual lumen)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8663
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 43750 was previously used to report G and J tube services (X1, X2, X5, X6, X7), which will now be reported using more specific codes. Mediare utilization for code 43750 for 2004 was 32754. An estimate of 25% of services reported using code 43750 are believed to be J-tube placement services that will now be reported using 494X2. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiveing these services is believed to be about 5% above that of Medicare. Medicare 204 utilization data finds that Diagnostic Radiology & Interventional Radiology provide 32.63% of these services, General Surgery provides 40% and Gastroenterology provides 15%, the balance is provided by various other specialties.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 2827 Percentage 32.63 %

Specialty General Surgery Frequency 3465 Percentage 39.99 %

Specialty Gatroenterology Frequency 1299 Percentage 14.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,250 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 43750 was previously used to report G and J tube services (X1, X2, X5, X6, X7), which will now be reported using more specific codes. Mediare utilization for code 43750 for 2004 was 32754. An estimate of 25% of services reported using code 43750 are believed to be J-tube placement services that will now be reported using 494X2. Medicare 204 utilization data finds that Diagnostic Radiology & Interventional Radiology provide 32.63% of these services, General Surgery provides 40% and Gastroenterology provides 15%, the balance is provided by various other specialties.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 2692 Percentage 32.63 %

Specialty General Surgery Frequency 3300 Percentage 40.00 %

Specialty Gastroenterology Frequency 1238 Percentage 15.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 49322 has a similar work RVU and physican times involved.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49442 Tracking Number KK3 Specialty Society Recommended RVU: **6.58**
Global Period: 010 RUC Recommended RVU: **3.87**

CPT Descriptor: Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old Caucasian male with history of sigmoid cancer that is non-resectable presents with megacolon, abdominal pain and vomiting. The colon is markedly dilated throughout. A rectal tube was placed, but did not reach the area of obstruction, so the patient is referred for cecostomy tube placement to allow decompression of the colon long-term.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Reviews recent CT or US of the abdomen (separately reportable) is performed to confirm an acceptable percutenous window.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Ensures EKG amd hemodynamic monitors are in place and functioning.
-Performs sterile prep and drapes the right lower quadrant of the abdomen.
-Applies topical anesthesia to the selected entry site.
-Uses fluoroscopic guidance to localize and directly puncture the cecal wall.
-Performs colonic pexy with 1-3 fastners; securing the colon to the abdominal wall.
-Uses fluoroscopic guidance to introduce a percutaenous needle into the cecum and passes a wire allowing serial dilatation.
-Introduces a peel-away sheath through which a 12-22 Fr. cecostomy tube is placed.

-Removes the peel away sheath and secures the retention device internally and secures the tube.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices and patency of the cecum.
-Injects contrast to confirm final tube placement.
-Places the system to ensure gravity drainage and applies a sterile dressing.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for abdominal complications.
-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD					
Specialty(s):	Interventional Radiology & Radiology					
CPT Code:	49442					
Sample Size:	375	**Resp N:**	15	**Response:** 4.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	2.00	10.00
Survey RVW:		2.75	4.20	**5.15**	6.91	9.00
Pre-Service Evaluation Time:				**43.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**12.0**		
Intra-Service Time:		10.00	30.00	**30.00**	60.00	75.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**40.0**	99231x **2.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49442	
	Specialty Recommended
Physician Work RVU:	6.58
Pre-Service Evaluation Time:	43.0
Pre-Service Positioning Time:	15.0
Pre-Service Scrub, Dress, Wait Time:	12.0
Intra-Service Time:	30.00
Immediate Post Service-Time:	15.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	20.0	99231x 1.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	23.0	99211x 0.0 12x 0.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49041	000	3.99	RUC Time

CPT Descriptor Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	CPT Code: 49442	Key Reference CPT Code: 49041	Source of Time RUC Time
Median Pre-Service Time	70.00	38.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**158.00**	**128.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.33
Physical effort required	3.67	3.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.33	3.00
Outcome depends on the skill and judgment of physician	4.00	3.33
Estimated risk of malpractice suit with poor outcome	3.67	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.33
Intra-Service intensity/complexity	3.67	3.00
Post-Service intensity/complexity	3.00	2.33

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. IWPUT was calculated using the median recommended RVU value, which resulted in a negative IWPUT of -0.3024. Therefore, the survey 75th percentile recommended RVU value was believed to be more accurate; IWPUT was calculated, as follows:

Pre-service RVU = 1.3964 = 0.0224*(43+15) + (0.0081*12)

Post-service RVU = 4.056 = (0.0224*15) + 0.76 + 0.76 + 1.28 + 0.92

RECOMMENDED RVU = 6.58

Intra-service RVU = 1.1276

IWPUT = 0.037587 = 1.1276/30

Per survey, typical E&M visits:

In patient	99231 – 2	Physician Work RVUs	0.76
Discharge Day Mgmt	99238 – 1	Physician Work RVUs	1.28
Office visit	99213 – 1	Physician Work RVUs	0.92

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 44300 and 74355

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 70
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 44300 was previously used to report percutaneous C- tube placement, which will now be reported using 494X3. Medicare utilization for code 44300 for 2004 was 3444. Those services reported by Diagnostic Radiology and Interventional Radiology using code 44300 will now be reported with code 494X3. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiveng these services is believed to be about 5% above that of Medicare. Per 2004 Medicare data, Diagnostic Radiology and Interventional Radiology represented only 1.91% of those reporting 44300.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 70 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 65
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 44300 was previously used to report percutaneous C- tube placement, which will now be reported using 494X3. Medicare utilization for code 44300 for 2004 was 3444. Those services reported by Diagnostic Radiology and Interventional Radiology using code 44300 will now be reported with code 494X3. Per 2004 Medicare data, Diagnostic Radiology and Interventional Radiology represented only 1.91% of those reporting 44300.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 65 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 38500 has a similar work RVU and physician times involved.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49446 Tracking Number KK4 Specialty Society Recommended RVU: **3.50**
Global Period: 000 RUC Recommended RVU: **2.94**

CPT Descriptor: Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report
(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 494X1 in addition to 494X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old male with paralysis secondary to cerebrovascular accident has suffered multiple episodes of aspiration pneumonia while on enteral feedings via gastrostomy tube. Gastroesophageal reflux is diagnosed and a conversion of the gastrostomy tube to gastro-jejunostomy has been requested.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 78%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Reviews recent CT or US of the abdomen (separately reportable) is performed to confirm an acceptable percutenous window.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Ensures EKG amd hemodynamic monitors are in place and functioning.
-Performs sterile prep of the gastrostomy tube site.
-Applies topical anesthesia to the selected entry site.
-Uses fluoroscopic guidance to place a guidewire over which the gastrostomy tube is removed.
-Advances a catheter through the existing tract which is then introduced across the pyloric channel into the jejunum.
-Exchanges the guidewire for a stiffwire over which the gastro-jejunostomy tube is advanced with the jejunal tip beyond the ligament of Treitz and te gastrostomy lumen positioned in the stomach.

-Removes guidewires and secures the retention balloon.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices and patency.

-Injects contrast through both lumens to confirm final tube positioning in both the jejunum and stomach.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for abdominal complications.
-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD					
Specialty(s):	Interventional Radiology & Radiology					
CPT Code:	49446					
Sample Size:	375	**Resp N:** 20	**Response:** 5.3 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		5.00	10.00	**15.00**	26.00	100.00
Survey RVW:		1.40	3.20	**3.50**	3.99	7.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**6.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		15.00	17.00	**30.00**	45.00	75.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49446		
		Specialty Recommended
Physician Work RVU:		3.50
Pre-Service Evaluation Time:		10.0
Pre-Service Positioning Time:		7.0
Pre-Service Scrub, Dress, Wait Time:		7.0
Intra-Service Time:		30.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36581	010	3.45	RUC Time

CPT Descriptor Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)

	CPT Code: 49446	Key Reference CPT Code: 36581	Source of Time RUC Time
Median Pre-Service Time	24.00	35.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	16.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**64.00**	**115.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.60	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.40	2.40
Urgency of medical decision making	3.00	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	3.60	3.20
Physical effort required	3.40	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.80
Outcome depends on the skill and judgment of physician	3.20	3.10

Estimated risk of malpractice suit with poor outcome	2.80	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.60	2.20
Intra-Service intensity/complexity	3.20	3.00
Post-Service intensity/complexity	2.20	2.20

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The workgroup supports the survey median recommended physician RVU of 3.50, which results in an IWPUT of 0.0759; calculated, as follows:

Pre-service RVU = 0.8874 = (0.0224*36) + (0.0081*10)

Post-service RVU = 0.336 = (0.0224*15)

MEDIAN RECOMMENDED RVU = 3.50

Intra-service RVU = 2.2766

IWPUT = 0.0759 = 2.2766 /30

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43761 and 74355

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8555
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 43761 was previously used to report percutaneous conversion to a -J tube, which will now be reported using 494X4. Medicare utilization for code 43761 for 2004 was 8148. Those services reported by Diagnostic Radiology and Intervenitonal Radiology using code 43761 will now be reported with code 494X4. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiveing these services is believed to be about 5% above that of Medicare. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 74.32% of those reporting 43761.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 6358 Percentage 74.31 %

Specialty Other Frequency 2197 Percentage 25.68 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,148 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 43761 was previously used to report percutaneous conversion to a -J tube, which will now be reported using 494X4. Medicare utilization for code 43761 for 2004 was 8148. Those services reported by Diagnostic Radiology and Intervenitonal Radiology using code 43761 will now be reported with code 494X4. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 74.32% of those reporting 43761.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 6056 Percentage 74.32 %

Specialty Other Frequency 2092 Percentage 25.67 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 45345 has a similar work RVU and physician time involved.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49450 Tracking Number KK5 Specialty Society Recommended RVU: **1.5**
Global Period: 000 RUC Recommended RVU: **1.14**

CPT Descriptor: Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old patient living in a nursing home after having a stroke is seen in the interventional suite after her gastrostomy tube was accidentally pulled out the previous day. The interventional radiologist examines the site of the gastrostomy, and finds that the entry remains open.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 58%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Probes site with catheter.
-Injects contrast into the tract for assessment.
-Maneuveres a wire through the tract into the stomach under fluoroscopic guidance.
-Advances the gastrostomy tube over the wire into position.
-Secures the retention device internally with the tube secured to the skin externally.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices and patency of the stomach.
-Places the system to ensure gravity drainage and applies a sterile dressing.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for abdominal complications.

-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD				
Specialty(s):	Interventional Radiology & Radiology				
CPT Code:	49450				
Sample Size:	375	**Resp N:** 20	**Response:** 5.3 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	6.00	10.00	**16.00**	28.00	100.00
Survey RVW:	1.00	1.50	**2.40**	3.00	4.59
Pre-Service Evaluation Time:			**25.0**		
Pre-Service Positioning Time:			**7.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	5.00	10.00	**15.00**	22.00	45.00
Immediate Post Service-Time:	**10.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49450	
	Specialty Recommended
Physician Work RVU:	1.50
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	7.0
Pre-Service Scrub, Dress, Wait Time:	7.0
Intra-Service Time:	15.00

Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49423	000	1.46	RUC Time

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 30.0 %

TIME ESTIMATES (Median)

	CPT Code: 49450	Key Reference CPT Code: 49423	Source of Time RUC Time
Median Pre-Service Time	24.00	15.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**49.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.17	2.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.17	2.33
Urgency of medical decision making	2.50	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.67	2.67
Physical effort required	2.50	2.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.83	1.83
Outcome depends on the skill and judgment of physician	2.33	2.17

Estimated risk of malpractice suit with poor outcome	2.33	2.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	2.33
Intra-Service intensity/complexity	2.83	2.67
Post-Service intensity/complexity	2.33	2.17

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. IWPUT was calculated using the median recommended RVU value, which resulted in an IWPUT of 0.10442, which is believed to be exceedingly high. The survey 25th percentile recommended RVU value was believed to be more accurate; IWPUT was calculated, as follows:

Pre-service RVU = 0.6097 = (0.0224*25) + (0.0081*7)

Post-service RVU = 0.224 = (0.0224*20)

25th PERCENTILE RECOMMENDED RVU = 1.50

Intra-service RVU = 0.6663

IWPUT = 0.04442 = 0.6663/15

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43760 and 74350

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 11751
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 43760 was previously used to report percutaneous replacement of a gastrostomy tube through an existing tract, which will now be reported using 494X5. Medicare utilization for code 43760 for 2004 was 72532. Those services reported by Diagnostic Radiology and Interventional Radiology using code 43760 will now be reported with code 494X5. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiving these services is believed to be about 5% above that of Medicare. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 15.43% of those reporting 43760.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 11751 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,192 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 43760 was previously used to report percutaneous replacement of a gastrostomy tube through an existing tract, which will now be reported using 494X5. Medicare utilization for code 43760 for 2004 was 72532. Those services reported by Diagnostic Radiology and Interventional Radiology using code 43760 will now be reported with code 494X5. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 15.43% of those reporting 43760.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 11192 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 36584 has a similar work RVU and physician time involved.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49451 Tracking Number KK6 Specialty Society Recommended RVU: **2.20**
Global Period: 000 RUC Recommended RVU: **1.82**

CPT Descriptor: Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 13-year-old child with permanent brain injury has a permanent indwelling jejunostomy tube that was inadvertently pulled out.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 61%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Probes site with catheter.
-Injects contrast into the tract for assessment.
-Maneuveres a wire through the tract into the jejunum under fluoroscopic guidance.
-Advances the jejunostomy tube over the wire into position.
-Secures the retention device.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices.
-injects contrast to confirm final feeding tube placement.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for intra-abdominal complications.
-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of tube, graduated feeding amounts, and acceptable residual levels

-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD				
Specialty(s):	Interventional Radiology & Radiology				
CPT Code:	49451				
Sample Size: 375	**Resp N:** 20	**Response:** 5.3 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	5.00	**10.00**	10.00	30.00
Survey RVW:	1.00	1.55	**2.20**	3.10	4.87
Pre-Service Evaluation Time:			**25.0**		
Pre-Service Positioning Time:			**6.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	5.00	13.00	**20.00**	28.00	45.00
Immediate Post Service-Time:	**12.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49451	
	Specialty Recommended
Physician Work RVU:	2.20
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	7.0
Pre-Service Scrub, Dress, Wait Time:	7.0
Intra-Service Time:	20.00

Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49423	000	1.46	RUC Time

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 35.0 %

TIME ESTIMATES (Median)

	CPT Code: 49451	Key Reference CPT Code: 49423	Source of Time RUC Time
Median Pre-Service Time	24.00	15.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**54.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.14
Urgency of medical decision making	2.50	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.86	2.71
Physical effort required	2.71	2.71

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	2.43	2.29

Estimated risk of malpractice suit with poor outcome	2.14	2.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.14	2.14
Intra-Service intensity/complexity	2.57	2.43
Post-Service intensity/complexity	2.14	2.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The workgroup supports the survey median recommended physician RVU of 2.20, which results in an IWPUT of 0.06613; calculated, as follows:

Pre-service RVU = 0.6086 = (0.0224*25) + (0.0081*6)

Post-service RVU = 0.2688 = (0.0224*12)

MEDIAN RECOMMENDED RVU = 2.20

Intra-service RVU = 1.3226

IWPUT = 0.06613 =1.3226/20

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43761 and 74355

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5133
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 43761 was previously used to report percutaneous replacement of jejunosotomy and gastro-jejunostomy tubes, which will now be reported using 494X6 and 494X7. Medicare utilization for code 43761 for 2004 was 8148. It is believed that 60% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 43761 will now be reported using code 494X6. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiving these services is believed to be about 5% above that of Medicare. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 74.32% of those reporting 43761.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 5133 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4889 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Code 43761 was previously used to report percutaneous replacement of jejunosotomy and gastro-jejunostomy tubes, which will now be reported using 494X6 and 494X7. Medicare utilization for code 43761 for 2004 was 8148. It is believed that 60% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 43761 will now be reported using code 494X6. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 74.32% of those reporting 43761.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 4889 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 91122 has a similar work RVU and physician time involved.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49452 Tracking Number KK7 Specialty Society Recommended RVU: **3.30**
Global Period: 000 RUC Recommended RVU: **2.81**

CPT Descriptor: Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old patient with a chronically indwelling gastro-jejunostomy tube is seen in the interventional suite the day after the tube was accidentally pulled out. The site is inspected and the tract remains open and without infection.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 74%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Optimizes anticoagulent status and platelet count prior to performance of the procedure.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Re-reviews applicable, available prior films.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Probes site with catheter.
-Injects contrast into the tract for assessment.
-Maneuveres a wire through the tract into the stomach and negotiates a catheter and wire through the pylorus, through the duodenum, into the jejunum under fluoroscopic guidance.
-Advances the gastro-jejunostomy tube over the wire into position.
-Secures the retention device.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices.
-Injects contrast to confirm final feeding tube placement.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for abdominal complications.

-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD					
Specialty(s):	Interventional Radiology & Radiology					
CPT Code:	49452					
Sample Size:	375	**Resp N:**	20	**Response:** 5.3 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		5.00	6.00	**10.00**	21.00	210.00
Survey RVW:		1.40	3.00	**3.30**	4.20	7.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**7.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		10.00	15.00	**28.00**	47.00	75.00
Immediate Post Service-Time:	**11.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49452	
	Specialty Recommended
Physician Work RVU:	3.30
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	7.0
Pre-Service Scrub, Dress, Wait Time:	7.0
Intra-Service Time:	28.00

Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49423	000	1.46	RUC Time

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 15.0 %

TIME ESTIMATES (Median)	CPT Code: 49452	Key Reference CPT Code: 49423	Source of Time RUC Time
Median Pre-Service Time	24.00	15.00	
Median Intra-Service Time	28.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**62.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.67	1.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.67	1.67
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	2.33
Physical effort required	2.33	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	1.67
Outcome depends on the skill and judgment of physician	2.33	1.67

Estimated risk of malpractice suit with poor outcome	1.67	1.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	2.00
Intra-Service intensity/complexity	2.67	1.67
Post-Service intensity/complexity	2.00	1.67

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The workgroup supports the survey median recommended physician RVU of 3.30, which results in an IWPUT of 0.0766; calculated, as follows:

Pre-service RVU = 0.9098 = (0.0224*37) + (0.0081*10)

Post-service RVU = 0.2464 = (0.0224*11)

MEDIAN RECOMMENDED RVU = 3.30

Intra-service RVU = 2.1438

IWPUT = 0.0766 = 2.1438 /28

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43761, 74355 and 74350

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3422
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 43761 was previously used to report percutaneous replacement of jejunosotomy and gastro-jejunostomy tubes, which will now be reported using 494X6 and 494X7. Medicare utilization for code 43761 for 2004 was 8148. It is believed that 40% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 43761 will now be reported using code 494X7. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiving these services is believed to be about 5% above that of Medicare. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 74.32% of those reporting 43761.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 3422 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,259 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 43761 was previously used to report percutaneous replacement of jejunosotomy and gastro-jejunostomy tubes, which will now be reported using 494X6 and 494X7. Medicare utilization for code 43761 for 2004 was 8148. It is believed that 60% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 43761 will now be reported using code 494X6. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 74.32% of those reporting 43761.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 3259 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 57460 has a similar work RVU and physician time.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49460 Tracking Number KK8 Specialty Society Recommended RVU: **2.00**
Global Period: 000 RUC Recommended RVU: **1.51**

CPT Descriptor: Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report
(Do not report code 494X9 in conjunction with codes 494X5-494X7, 494X10)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old female with history of stroke and dysphagia has a chronically indwelling gastrostomy tube for enteral nutrition. Her meds are crushed and administered through the G-tube also. Interventional radiology is consulted because the gastrostomy tube is plugged and cannot be flushed. The patient has not received fluids, nutrition or medication for 24 hours.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 65%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Estimates the range of guiding catheters/sheaths, guidewires, and other devices that may be required and ensures all are available for use.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices.
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Assesses current clinical status.
-Examines the catheter to ensure it is still in place.
-Attempts to vigorously flush the catheter and reasseses finding the catheter cannot be flushed.
-Checks IV set up.
-Directs administration of intravenous antibiotics.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Moderate sedation is administered.
-Verifies proper positioning of catheter under fluoroscopic imaging.
-Drapes the catheter and skin site and attempts to advance a wire through the catheter to dislodge impacted material.
-Tries numerous types of guidewires attempting to dislodge imapacted material.
-Uses a mechanical device ot break up the material.
-Advances a wire through the softened material.
-Repeatidly passes the wire to break up all impacted material; pushing it back into the stomach.
-Flushes the catheter and applies new dressing.
-Uses continuous imaging guidance and contrast injections at each step to insure proper position of devices.

-Injects contrast to confirm feeding tube is fully functioning.

Description of Post-Service Work: The physician,
-Writes orders for pain control, management of outputs and surveillance for abdominal complications.
-Commuicates to the family, POA, and managing service (if other than operator).
-Perscribes care of tube, graduated feeding amounts, and acceptable residual levels
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD				
Specialty(s):	Interventional Radiology & Radiology				
CPT Code:	49460				
Sample Size: 375	**Resp N:** 19	**Response:** 5.0 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	4.00	6.00	**10.00**	18.00	30.00
Survey RVW:	0.80	1.25	**2.00**	2.63	3.65
Pre-Service Evaluation Time:			**25.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	7.00	13.00	**15.00**	19.00	30.00
Immediate Post Service-Time:	**13.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49460		
		Specialty Recommended
Physician Work RVU:		**2.00**
Pre-Service Evaluation Time:		**10.0**
Pre-Service Positioning Time:		**7.0**
Pre-Service Scrub, Dress, Wait Time:		**7.0**
Intra-Service Time:		**15.00**
Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36581	010	3.45	**RUC Time**

CPT Descriptor Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 1				
MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 2				

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 15.7 %

TIME ESTIMATES (Median)	CPT Code: 49460	Key Reference CPT Code: 36581	Source of Time RUC Time
Median Pre-Service Time	24.00	35.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	16.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**49.00**	**115.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.67	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.67	1.67
Urgency of medical decision making	3.00	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.33	2.00
Physical effort required	2.00	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.33
Outcome depends on the skill and judgment of physician	2.33	2.67

Estimated risk of malpractice suit with poor outcome	2.67	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.67	1.67
Intra-Service intensity/complexity	2.67	2.33
Post-Service intensity/complexity	1.67	2.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The workgroup supports the survey median recommended physician RVU of 2.00, which results in an IWPUT of 0.0563; calculated, as follows:

Pre-service RVU = 0.865 = (0.0224*35) + (0.0081*10)

Post-service RVU = 0.2912 = (0.0224*13)

MEDIAN RECOMMENDED RVU = 2.00

Intra-service RVU = 0.8438

IWPUT = 0.0563 = 0.8438/15

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 44799 and 74355

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 366
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Unlisted code 44799 was previously used to report mechanical removal of obstructive material from a enteral tube, which will now be reported using 494X9. Medicare utilization for code 44799 for 2004 was 1045. It is believed that 90% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 44799 will now be reported using code 494X9. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiving these services is believed to be about 5% above that of Medicare. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 33.35% of those reporting 44799.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 366 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 349
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Unlisted code 44799 was previously used to report mechanical removal of obstructive material from a enteral tube, which will now be reported using 494X9. Medicare utilization for code 44799 for 2004 was 1045. It is believed that 90% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 44799 will now be reported using code 494X9. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 33.35% of those reporting 44799.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 349 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 46608 has similar a work RVU and physician time.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49465 Tracking Number KK9 Specialty Society Recommended RVU: **0.76**
Global Period: 000 RUC Recommended RVU: **0.62**

CPT Descriptor: Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report
(Do not report code 494X10 in conjunction with codes 494X1-494X9)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old patient with a chronically indwelling jejunostomy tube is seen after the catheter was accidentally caught on the bedrail and partially dislodged. The nursing staff advanced the catheter back into the patient, but confirmation of location of the tip of the catheter is desired prior to resuming feedings.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician,
-Discusses procedure details, including alternatives and risks with the patient (or more commonly with the power of attorney (POA) overseeing care of the patient) and family and informed consent is reviewed with patient and family.
-Checks the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues.
-Dons radiation protection device.

Description of Intra-Service Work: The physician,
-Assesses current clinical status.
-Examines the catheter to ensure it is still in place.
-Brings the patient into the angiography suite and positions the patient (or supervises the postioning of the patient) in a supine position.
-Ensures patient is properly protected from radiation.
-Injects contrast through the catheter and verifies proper positioning of catheter under fluoroscopic imaging.

Description of Post-Service Work: The physician,
-Writes orders to resume feedings.
-Commuicates to the family, POA, and managing service (if other than operator)
-Dictates, reviews, and signs report of the procedure including review and reporting on related archived images.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD		
Specialty(s):	Interventional Radiology & Radiology		
CPT Code:	49465		
Sample Size: 375	**Resp N:** 19	**Response:** 5.0 %	

CPT Code: 49465

Sample Type: Panel						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		5.00	10.00	**10.00**	20.00	50.00
Survey RVW:		0.70	0.75	**0.76**	1.19	2.25
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**6.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		2.00	5.00	**8.00**	10.00	20.00
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 49465		
		Specialty Recommended
Physician Work RVU:		0.76
Pre-Service Evaluation Time:		10.0
Pre-Service Positioning Time:		7.0
Pre-Service Scrub, Dress, Wait Time:		7.0
Intra-Service Time:		8.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49424	000	0.76	RUC Time

CPT Descriptor Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 47.3 %

TIME ESTIMATES (Median)	CPT Code: 49465	Key Reference CPT Code: 49424	Source of Time RUC Time
Median Pre-Service Time	24.00	12.00	
Median Intra-Service Time	8.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**42.00**	**37.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	1.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.56	1.67
Urgency of medical decision making	4.63	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.22	1.22
Physical effort required	1.33	1.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.33	1.33
Outcome depends on the skill and judgment of physician	2.00	1.78

Estimated risk of malpractice suit with poor outcome	1.89	1.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.67	1.67
Intra-Service intensity/complexity	1.56	1.56
Post-Service intensity/complexity	1.67	1.56

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The workgroup supports the survey median recommended physician RVU of 0.76, which results in an IWPUT of 0.01893; calculated, as follows:

Pre-service RVU = 0.3846 = (0.0224*15) + (0.0081*6)

Post-service RVU = 0.224 = (0.0224*10)

MEDIAN RECOMMENDED RVU = 0.76

Intra-service RVU = 0.1514

IWPUT = 0.01893 = 0.1514 /8

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20501 and 76080

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8141
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 20501 was previously used to report contrast injetions performed for the radiological evaluation of feeding tubes, which will now be reported using 494X10. Medicare utilization for code 20501 for 2004 was 7753. It is believed that 50% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 20501 will now be reported using code 494X10. Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiving these services is believed to be about 5% above that of Medicare. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 95.42% of those reporting 20501.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 7768 Percentage 95.41 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,753 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 20501 was previously used to report contrast injetions performed for the radiological evaluation of feeding tubes, which will now be reported using 494X10. Medicare utilization for code 20501 for 2004 was 7753. It is believed that 50% of the services previously reported by Diagnostic Radiology and Interventional Radiology using code 20501 will now be reported using code 494X10. Per Medicare 2004 data, Diagnostic Radiology and Interventional Radiology represented 95.42% of those reporting 20501.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 7398 Percentage 95.42 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 36598 has a similar work RVU and physician time.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43760 Tracking Number KK11 Specialty Society Recommended RVU: **1.10**
Global Period: 000 RUC Recommended RVU: **0.90**

CPT Descriptor: Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76 year old female suffering from significant malnutrition previously required placement of a percutaneous gastrostomy tube. The gastrostomy has become clogged; attempts to establish luminal patency have been unsuccessful. The physician is requested to remove the obstructed gastrostomy catheter and replace it.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 18%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- The patient's chart is reviewed and the order confirmed
- Discussion with staff about difficulties encountered with current tube
- Pertinent lab reviewed
- The procedure is discussed with the patient or family

Description of Intra-Service Work:
- The existing tube site is examined.
- Balloon deflated as appropriate
- The existing gastrostomy tube is removed by traction
- New balloon tube is tested, inserted, and balloon filled to specification
-Tube pulled back and secured, and checked for patency
- Dressing applied and patient tolerance assessed

Description of Post-Service Work:
- The procedure is documented in the patient's chart
- The referring physician and nursing staff are notified of the result of the procedure
- The report of the procedure is recorded in the medical record
- Replacement supplies are ordered (physician office)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Joel V. Brill, MD (AGA), Maurits Wiersema, MD (AGA) and Klaus Mergener, MD, PhD, CPE (ASGE)				
Specialty(s):	American Gastroenterological Association (AGA) & American Society for Gatsrointestinal Endoscopy (ASGE)				
CPT Code:	43760				
Sample Size: 250	**Resp N:** 40	**Response:** 16.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	2.00	5.00	**10.00**	20.00	100.00

CPT Code: 43760

Survey RVW:		0.20	0.95	**1.15**	1.32	2.99
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		2.00	5.00	**10.00**	10.00	20.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 43760	
	Specialty Recommended
Physician Work RVU:	**1.15**
Pre-Service Evaluation Time:	**10.0**
Pre-Service Positioning Time:	**5.0**
Pre-Service Scrub, Dress, Wait Time:	**2.0**
Intra-Service Time:	**10.00**

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.42	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
45330	000	106,524	0.96	**RUC Time**

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 17.5 %

TIME ESTIMATES (Median)	CPT Code: 43760	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	17.00	5.00	
Median Intra-Service Time	10.00	25.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**32.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.23	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.70	2.70
Urgency of medical decision making	2.68	2.48
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.05	2.80
Physical effort required	2.95	2.68
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.08	2.55

Outcome depends on the skill and judgment of physician	3.15	2.93
Estimated risk of malpractice suit with poor outcome	3.53	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.60	2.35
Intra-Service intensity/complexity	2.88	2.85
Post-Service intensity/complexity	2.50	2.23

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of code 43760, Change of gastrostomy tube, percutaneous, without imaging or guidance. Code 43760, an existing code, was revised during the February 2007 CPT Editorial Panel meeting. *After reviewing the survey data, the societies recommend maintaining the current work relative value unit (WRVU) of the code: 1.10 WRVUs. The recommended value of 1.10 WRVU is less than the survey median of 1.15.*

Survey Process

The survey was disseminated to a randomly generated list of 250 members of AGA and ASGE. A total of 40 responses (16% response rate) were received.

Data Evaluation

RUC Advisors from both AGA and ASGE reviewed the survey data. The advisors assessed the adequacy of the survey data and the recommendation of 1.10 WRVUs by comparing the surveyed code to reference codes: 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 99214 *Office or other outpatient visit for the evaluation and management of an established patient.* Additionally, the data currently existing in the RUC database for 43760 was also considered.

An equal number of survey respondents (7) chose codes 45330 and 99214 as their reference service. No other reference service was chosen with as high a frequency. Based on these codes' inclusion on the MPC list and the comparability of existing time and WRVU values, the advisors determined that these codes were appropriate comparisons.

The chart below summarizes the data that was considered.

Analysis of Survey Data for 43760: Physician Time and WRVU Data for Reference Services

CPT Code	Pre Time	Intra Time	Post Time	Total Time	WRVU	IWPUT
43760 (2007 survey)	30	10	5	45	1.10	.039

43760 (currently in database)	24	16	9	49	1.10	.036
45330 *	7	17	8	32	0.96	.037
99214*	5	25	10	40	1.42	.043

* Survey reference service

After comparing the time data and IWPUT values of the surveyed code to the reference codes and the values currently in the RUC database for 43760, the advisors concluded that the survey data supported the recommended value of 1.10 WRVUs.

43760 versus 45330
The 0.14 higher WRVU value for surveyed code 43760 to reference service 45330 was felt to be justified given the greater time and intensity of code 43760. This higher intensity is also reflected when comparing the typical patient for these two procedures. The majority of patients undergoing code 45330 are seen on a scheduled basis. Code 43760 is typically performed on patients with malnutrition who are no longer able to maintain adequate enteral intake due to blockage / leakage / malfunction of the gastrostomy tube requiring physician expertise for removal and replacement.

43760 versus 99214
When comparing surveyed code 43760 to code 99214, advisors agreed that a lower WRVU for code 43760 was appropriate. The lower value recommended for code 43760 reflects the less intra-service time and roughly the similar intensity. This similarity in intensity is reflected in the survey responses to questions related to intensity of service time segments.

43760 2007 Survey Value versus 43760 Current Value
The societies and their advisors compared the surveyed code 43760 with the current value of 43760. The advisors agreed that the time and intensity of the two procedures reflected the reality that the overall work of the procedure had stayed the same and validated their recommendation that the value of 1.10 WRVUs should be maintained.

The advisors considered the actions of the CPT Editorial Panel whose revision of the code removed language in the code related to radiological services. The question of how this revision should impact the value of the code was raised. The societies reviewed the survey data from when this code went through the 2005 Five-Year review, as well as the recently completed survey of Gastroenterologists. Typically, when a GI physician performs this procedure, radiological services are not performed. Therefore the advisors concluded that the overall work of this procedure has not changed. This conclusion is supported by the minor differences in time between the 2007 surveyed time for code 43760 and the time that is currently in the RUC database.

In view of the above, the AGA and ASGE recommend 1.10 WRVUs for surveyed code 43760.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and

accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43760, Change of gastrostomy tube

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology	How often? Commonly
Specialty Emergency Medicine	How often? Sometimes
Specialty General Surgery	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 64900
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The majority of these procedures are performed on Medicare beneficiaries. We estimate that commercial patients expand the patient volume by 10%. We believe this would not materially affect the relative frequency and percentages for those specialties that perform this procedure.

Specialty Gastroenterology	Frequency 24000	Percentage 36.97 %
Specialty Emergency Medicine	Frequency 16000	Percentage 24.65 %
Specialty General Surgery	Frequency 12300	Percentage 18.95 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 59,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 utilization for code 43760 was 71,619. Of this, 17.77% of procedures were reported by radiology, which will now be reported by new codes specific for placement of gastrostomy under radiological guidance.

Specialty Gastroenterology	Frequency 21800	Percentage 36.94 %
Specialty Emergency Medicine	Frequency 14500	Percentage 24.57 %
Specialty General Surgery	Frequency 11150	Percentage 18.89 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

49440- Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 494X4 in addition to 49440)

49441- Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

(For conversion of gastrostomy tube to gastro-jejunostomy tube, use 494X4)

49442- Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

Sample Size N/A Response Rate: (%): N/A Global Period: 010

Expert Panel Used to Develop Recommendation

Geographic Practice Setting %: **All geographical practice settings represented**

Type of Practice %: **All practice types represented**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Members known to provide the service for which practice expense inputs are being developed in an in-facility setting were contacted to provide inputs. Like inputs were identified. Society RUC workgroup members evaluated unique inputs for inclusion as appropriate within the context of established standard inputs for like and/or related procedures/services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Schedule procedure and confirm applicable supplies and devices are in inventory**
- **Retrieve and compile all relevant clinical information for patient record for review by physician including incorporation of all relevant clinical information, verify orders, confirm procedure protocol with physician**
- **Contact patient the day before procedure to confirm adherence to pre-procedure protocol**

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- **Initiate phone calls for physician and call in prescriptions as applicable**
- **Support physician in providing follow-up E&M services**

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Non Facility Direct Inputs

CPT Long Descriptor:

49440- Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 494X4 in addition to 49440)

49441- Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

(For conversion of gastrostomy tube to gastro-jejunostomy tube, use 494X4)

49442- Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

Sample Size N/A Response Rate: (%): N/A Global Period: 010

Expert Panel Used to Develop Recommendation

Geographic Practice Setting %: **All geographical practice settings represented**

Type of Practice %: **All practice types represented**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Members known to provide the service for which practice expense inputs are being developed in a non-facility setting were contacted to provide inputs. Industry was contacted as applicable regarding current pricing for new devices and/or existing devices for which there has been a known price increase. Like inputs were identified. Society RUC workgroup members evaluated unique inputs for inclusion as appropriate within the context of established standard inputs for like and/or related procedures/services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Schedule procedure and confirm applicable supplies and devices are in inventory**
- **Retrieve and compile all relevant clinical information for patient record for review by physician including incorporation of all relevant clinical information, verify orders, confirm procedure protocol with physician**
- **Contact patient the day before procedure to confirm adherence to pre-procedure protocol.**

Intra-Service Clinical Labor Activities:

- **Review and prepare chart to insure completeness in preparation for physician review**
- **Greet patient and provide gowning**
- **Reaffirm informed consent and obtain vital signs**
- **Prepare room including locating and preparation of all applicable devices and supplies**
- **Prepare patient for procedure and set up IV**
- **Assist physician in performing procedure**
- **Assist physician in monitoring moderate (conscious) sedation**

Post-Service Clinical Labor Activities:

- **Monitor patient post procedurally, checking vital signs every 20 minutes**
- **Clean room in accordance with OSHA regulations**
- **Check wound and review post procedure instructions with patient**
- **Review x-ray and lab results for physician review and interpretation with incorporation in patients medical record**
- **Initiate phone calls for physician and call in prescriptions as applicable**
- **Support physician in providing follow up E&M services**

Please see corresponding PERC spreadsheet for additional detail.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor:

49446 – Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 494X1 in addition to 49446)

49450 – Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

49451 – Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

49452 – Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

49460 – Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report

(Do not report code 49460 in conjunction with codes 49450-49452, 49465)

49465 – Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report

(Do not report code 49465 in conjunction with codes 494X1-49460)

Sample Size N/A Response Rate: (%): N/A Global Period: 010

Expert Panel Used to Develop Recommendation

Geographic Practice Setting %: **All geographical practice settings represented**

Type of Practice %: **All practice types represented**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Members known to provide the service for which practice expense inputs are being developed in an in-facility setting were contacted to provide inputs. Like inputs were identified. Society RUC workgroup members evaluated unique inputs for inclusion as appropriate within the context of established standard inputs for like and/or related procedures/services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Schedule procedure and confirm applicable supplies and devices are in inventory**
- **Retrieve and compile all relevant clinical information for patient record for review by physician including incorporation of all relevant clinical information, verify orders, confirm procedure protocol with physician**
- **Contact patient the day before procedure to confirm adherence to pre-procedure protocol**

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- **Initiate phone calls for physician and call in prescriptions as applicable**

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

49446 – Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

(For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, report code 494X1 in addition to 49446)

49450 – Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

49451 – Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

49452 – Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report

49460 – Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report

(Do not report code 49460 in conjunction with codes 49450-49452, 49465)

49465 – Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report

(Do not report code 49465 in conjunction with codes 494X1-49460)

Sample Size N/A Response Rate: (%): N/A Global Period: 010

Expert Panel Used to Develop Recommendation

Geographic Practice Setting %: **All geographical practice settings represented**

Type of Practice %: **All practice types represented**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Members known to provide the service for which practice expense inputs are being developed in a non-facility setting were contacted to provide inputs. Industry was contacted as applicable regarding current pricing for new devices and/or existing devices for which there has been a known price increase. Like inputs were identified. Society RUC workgroup members evaluated unique inputs for inclusion as appropriate within the context of established standard inputs for like and/or related procedures/services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Schedule procedure and confirm applicable supplies and devices are in inventory**
- **Retrieve and compile all relevant clinical information for patient record for review by physician including incorporation of all relevant clinical information, verify orders, confirm procedure protocol with physician**
- **Contact patient the day before procedure to confirm adherence to pre-procedure protocol.**

Intra-Service Clinical Labor Activities:

- **Review and prepare chart to insure completeness in preparation for physician review**
- **Greet patient and provide gowning**
- **Reaffirm informed consent and obtain vital signs**
- **Prepare room including locating and preparation of all applicable devices and supplies**
- **Prepare patient for procedure and set up IV**
- **Assist physician in performing procedure**
- **Assist physician in monitoring moderate (conscious) sedation**

Post-Service Clinical Labor Activities:

- **Monitor patient post procedurally, checking vital signs every 20 minutes**
- **Clean room in accordance with OSHA regulations**
- **Check wound and review post procedure instructions with patient**
- **Review x-ray and lab results for physician review and interpretation with incorporation in patients medical record**
- **Initiate phone calls for physician and call in prescriptions as applicable**

Please see corresponding PERC spreadsheet for additional detail.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor:

Sample Size:_____ Response Rate: (%):_____ Global Period: 000

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Gastroenterological Association (AGA) and American Society for Gastrointestinal Endoscopy (ASGE) RUC Advisors reviewed the practice expense data for code 43760 using the approved inputs from the February 2005 PEAC meeting as a starting point. The practice expenses have been updated to reflect the changes in the CPT descriptor for 43760 for 2008, specifically removing inputs and clinical staff functions related to imaging or guidance.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Conduct follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:
- None

Post-Service Clinical Labor Activities:
- Conduct phone calls/ call in prescriptions

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

Sample Size:_____ Response Rate: (%):_____ Global Period: 000

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Gastroenterological Association (AGA) and American Society for Gastrointestinal Endoscopy (ASGE) RUC Advisors reviewed the practice expense data for code 43760 using the approved inputs from the February 2005 PEAC meeting as a starting point. The practice expenses have been updated to reflect the changes in the CPT descriptor for 43760 for 2008, specifically removing inputs and clinical staff functions related to imaging or guidance.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- None

Intra-Service Clinical Labor Activities:
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient
- Sedate / apply anesthesia
- Assist physician in performing procedure
- Clean room/equipment by physician staff
- Check dressings & wound/home care instructions/ coordinate office visits/ prescriptions

Post-Service Clinical Labor Activities:
- Conduct phone calls/ call in prescriptions

	A	B	C	D	E	F	G	H	I
1	April 2007			49440		49441		49442	
2	AMA/Specialty Society RVS Update Committee Recommendation			Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			010	010	010	010	010	010
5	TOTAL CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	55.0	0.0	55.0	0.0	61.0	0.0
6	TOTAL CLINICAL LABOR TIME (Angio Tech)	L041B	RT	62.8	0.0	112.6	0.0	62.8	0.0
7	TOTAL CLINICAL LABOR TIME (RN)	L051A	RN	47.0	27.0	77.0	27.0	47.0	36.0
8	PRE-SERV CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	9.0	0.0	9.0	0.0	9.0	0.0
9	PRE-SERV CLINICAL LABOR TIME (ANGIO Tech)	L041B	RT	6.0	0.0	6.0	0.0	6.0	0.0
10	SERVICE PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	19.0	0.0	19.0	0.0	16.0	0.0
11	SERVICE PERIOD CLINICAL LABOR TIME (ANGIO tech)	L041B	RT	57	0	107	0	57	0
12	SERVICE PERIOD CLINICAL LABOR TIME (RN)	L051A	RN	47	0	77	0	47	0
13	POST-SERV PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0
14	POST-SERV PERIOD CLINICAL LABOR TIME (RN)	L037D	RN/LPN/MTA	27.0	27.0	27.0	27.0	36.0	36.0
15	PRE-SERVICE								
16	Start: Following visit when decision for surgery or procedure made								
17	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3		3		3	
18	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3	
19	Schedule space and equipment in facility	L037D	RN/LPN/MTA						
20	Provide pre-service education/obtain consent								
21	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3	
22	Other Clinical Activity (please specify): Retreive prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocal with interpreting MD	L041B	RT	6		6		6	
23	End:When patient enters office/facility for surgery/procedure								
24	SERVICE PERIOD								
25	Start: When patient enters office/facility for surgery/procedure								
26	Pre-service services								
27	Review charts	L037D	RN/LPN/MTA	2		2		2	
28	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3		3	
29	Obtain vital signs	L051A	RN/LPN/MTA	5		5		5	
30	Provide pre-service education/obtain consent	L051A	RN/LPN/MTA	3		3		3	
31									
32	Prepare room, equipment, supplies								
33	Prepare room, equipment, supplies	L041B	RT	2		2		2	
34	Setup scope (non facility setting only)								
35	Prepare and position patient/ monitor patient	L041B	RT	2		2		2	
36	Sedate/apply anesthesia	L051A	RN	2		2		2	
37	Intra-service								
38	Assist physician in performing procedure	L041B	RT	30		60		30	
39	Assist physician MCS monitoring Assist physician MCS monitoring	L051A	RN	30		60		30	
40	Assist physician with image acquisition performing procedure	L041B	RT	20		40		20	
41	Post-Service								
42	Monitor pt. following service/check tubes, monitors, drains.	L051A	RN	15		15		15	
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3			
44	Clean room/equipment by physician staff								
45	Clean Scope								
46	Clean Surgical Instrument Package								
47	Complete diagnostic forms, lab & X-ray requisitions								
48	Review/read X-ray, lab, and pathology reports								
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN/LPN/MTA	3		3		3	
50	Discharge day management 99238 --12 minutes 99239 --15 minutes								
51	Other Clinical Activity (please specify): post procedure image processing		RT	3		3		3	
52	End: Patient leaves office								
53	POST-SERVICE Period								
54	Start: Patient leaves office/facility								
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA					0	0
56	*Office visits:*								
57	*List Number and Level of Office Visits*								
58	99211 16 minutes		16						
59	99212 27 minutes		27	1	1	1	1		
60	99213 36 minutes		36					1	1
61	99214 53 minutes		53						
62	99215 63 minutes		63						
63	Other								
64	*Total Office Visit Time*			27	27	27	27	36	36
65	Other Activity (please specify)								
66	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
1	April 2007			49440		49441		49442	
2	AMA/Specialty Society RVS Update Committee Recommendation			Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
67	MEDICAL SUPPLIES	CMS Code?	Unit						
68	pack, EM visit	SA047	pack	2	1	2	1	2	1
69	pack, conscious sedation	SA044	pack	1		1		1	
70	additional sterile gloves	SB024	item	3		3		3	
71	lidocaine	SH047	ml	20		20		20	
72	needle 25 G	SC049	item	4		4		4	
73	saline flush syringe	SH065	item	2		2		2	
74	needle , 18 G	SC029	item	1		1		1	
75	guidewire, steerable (Transcend)	SD175	item	1		1		1	
76	guidewire, stiff	SD090	item	1		1		1	
77	guidewire, steerable (Hi Torque)	SD174	item						
78	guidewire, torque	SD176	item						
79	dilators 6-Fand 20-F	SD043	item	2		2		2	
80	sheath, peel away	SD206	item	1		1		1	
81	kit, guidewire introducer (Micro-Stick)	SA016	item	1		1		1	
82	gastrostomy tube	NEW	item	1				1	
83	jejunostomy	NEW	item			1			
84	x-ray ID card (flashcard)	SK093	item					1	
85	film, x-ray 14 inx17in	SK034	item	2		2		2	
86	x-ray envelope	SK091	item					1	
87	x-ray developer solution	SK089	oz	2		2		2	
88	x-ray fixer solution	SK092	oz	2		2		2	
89	disinfectnat, surface (Envirocide, Sanizide)	SM013	oz	1		1		1	
90	computer media, dvd	SK013	item	1		1		1	
91	drape sterile, c-arm fluoro	SB008	item	1		1		1	
92									
93	Equipment	CMS Code?	Unit						
94	Angio suite	EL011		1		1		1	
95	pulse oximeter	EQ211		1		1		1	
96	ECG, 3-channel (with Sp02, NIBR)	EQ011		1		1		1	
97	film alternator	ED024		1		1		1	
98	Film printer laser	ED032		1		1		1	
99	stretcher	EF018		1		1		1	
100	Infusion pump	EQ032		1		1		1	
101	oxygen tank								
102									

	A	B	C	J	K	L	M	N	O
1	April 2007			49446		49450		49451	
2	AMA/Specialty Society RVS Update Committee Recommendation			Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000
5	TOTAL CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	25.0	0.0	25.0	0.0	25.0	0.0
6	TOTAL CLINICAL LABOR TIME (Angio Tech)	L041B	RT	62.8	0.0	37.9	0.0	46.2	0.0
7	TOTAL CLINICAL LABOR TIME (RN)	L051A	RN	47.0	0.0	17.0	0.0	17.0	0.0
8	PRE-SERV CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	9.0	0.0	9.0	0.0	9.0	0.0
9	PRE-SERV CLINICAL LABOR TIME (ANGIO Tech)	L041B	RT	6.0	0.0	6.0	0.0	6.0	0.0
10	SERVICE PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	16.0	0.0	16.0	0.0	16.0	0.0
11	SERVICE PERIOD CLINICAL LABOR TIME (ANGIO tech)	L041B	RT	57	0	32	0	40	0
12	SERVICE PERIOD CLINICAL LABOR TIME (RN)	L051A	RN	47	0	17	0	17	0
13	POST-SERV PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0
14	POST-SERV PERIOD CLINICAL LABOR TIME (RN)	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0
15	PRE-SERVICE								
16	Start: Following visit when decision for surgery or procedure made								
17	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3		3		3	
18	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3	
19	Schedule space and equipment in facility	L037D	RN/LPN/MTA						
20	Provide pre-service education/obtain consent								
21	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3	
22	Other Clinical Activity (please specify): Retreive prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocal with interpreting MD	L041B	RT	6		6		6	
23	End:When patient enters office/facility for surgery/procedure								
24	SERVICE PERIOD								
25	Start: When patient enters office/facility for surgery/procedure								
26	Pre-service services								
27	Review charts	L037D	RN/LPN/MTA	2		2		2	
28	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3		3	
29	Obtain vital signs	L051A	RN/LPN/MTA	5		5		5	
30	Provide pre-service education/obtain consent	L051A	RN/LPN/MTA	3		3		3	
31									
32	Prepare room, equipment, supplies								
33	Prepare room, equipment, supplies	L041B	RT	2		2		2	
34	Setup scope (non facility setting only)								
35	Prepare and position patient/ monitor patient	L041B	RT	2		2		2	
36	Sedate/apply anesthesia	L051A	RN	2		2		2	
37	Intra-service								
38	Assist physician in performing procedure	L041B	RT	30		15		20	
39	Assist physician MCS monitoring. Assist physician MCS monitoring	L051A	RN	30					
40	Assist physician with image acquisition performing procedure	L041B	RT	20		10		13	
41	Post-Service								
42	Monitor pt. following service/check tubes, monitors, drains.	L051A	RN	15		15		15	
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
44	Clean room/equipment by physician staff								
45	Clean Scope								
46	Clean Surgical Instrument Package								
47	Complete diagnostic forms, lab & X-ray requisitions								
48	Review/read X-ray, lab, and pathology reports								
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN/LPN/MTA	3		3		3	
50	Discharge day management 99238 --12 minutes 99239 --15 minutes								
51	Other Clinical Activity (please specify): post procedure image processing		RT	3		3		3	
52	End: Patient leaves office								
53	POST-SERVICE Period								
54	Start: Patient leaves office/facility								
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	0	0	0	0	0
56	*Office visits*								
57	*List Number and Level of Office Visits*								
58	99211 16 minutes		16						
59	99212 27 minutes		27						
60	99213 36 minutes		36						
61	99214 53 minutes		53						
62	99215 63 minutes		63						
63	Other								
64	*Total Office Visit Time*			0	0	0	0	0	0
65	Other Activity (please specify)								
66	End: with last office visit before end of global period								

	A	B	C	J	K	L	M	N	O
1	April 2007			49446		49450		49451	
2	AMA/Specialty Society RVS Update Committee Recommendation			Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
67	MEDICAL SUPPLIES	CMS Code	Unit						
68	pack, EM visit	SA047	pack	1		1		1	
69	pack, conscious sedation	SA044	pack	1					
70	additional sterile gloves	SB024	item	3		2		2	
71	lidocaine	SH047	ml	20		20		20	
72	needle 25 G	SC049	item	4		4		4	
73	saline flush syringe	SH065	item	2		2		2	
74	needle , 18 G	SC029	item	1		1		1	
75	guidewire, steerable (Transcend)	SD175	item	1		1		1	
76	guidewire, stiff	SD090	item	1		1		1	
77	guidewire, steerable (Hi Torque)	SD174	item						
78	guidewire, torque	SD176	item						
79	dilators 6-Fand 20-F	SD043	item	2		2		2	
80	sheath, peel away	SD206	item	1		1		1	
81	kit, guidewire introducer (Micro-Stick)	SA016	item	1		1		1	
82	gastrostomy tube	NEW	item			1			
83	jejunostomy	NEW	item	1				1	
84	x-ray ID card (flashcard)	SK093	item	1		1		1	
85	film, x-ray 14 inx17in	SK034	item	2		2		2	
86	x-ray envelope	SK091	item	1		1		1	
87	x-ray developer solution	SK089	oz	2		2		2	
88	x-ray fixer solution	SK092	oz	2		2		2	
89	disinfectnat, surface (Envirocide, Sanizide)	SM013	oz	1		1		1	
90	computer media, dvd	SK013	item	1		1		1	
91	drape sterile, c-arm fluoro	SB008	item	1		1		1	
92									
93	Equipment	CMS Code	Unit						
94	Angio suite	EL011		1		1		1	
95	pulse oximeter	EQ211		1					
96	ECG, 3-channel (with Sp02, NIBR)	EQ011		1					
97	film alternator	ED024		1		1		1	
98	Film printer laser	ED032		1		1		1	
99	stretcher	EF018		1		1		1	
100	Infusion pump	EQ032		1					
101	oxygen tank								
102									

	A	B	C	P	Q	R	S
1	April 2007			49452		49460	
2	AMA/Specialty Society RVS Update Committee Recommendation			Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			000	000	000	000
5	TOTAL CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	25.0	0.0	25.0	0.0
6	TOTAL CLINICAL LABOR TIME (Angio Tech)	L041B	RT	59.5	0.0	37.9	0.0
7	TOTAL CLINICAL LABOR TIME (RN)	L051A	RN	17.0	0.0	17.0	0.0
8	PRE-SERV CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	9.0	0.0	9.0	0.0
9	PRE-SERV CLINICAL LABOR TIME (ANGIO Tech)	L041B	RT	6.0	0.0	6.0	0.0
10	SERVICE PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	16.0	0.0	16.0	0.0
11	SERVICE PERIOD CLINICAL LABOR TIME (ANGIO tech)	L041B	RT	53	0	32	0
12	SERVICE PERIOD CLINICAL LABOR TIME (RN)	L051A	RN	17	0	17	0
13	POST-SERV PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0
14	POST-SERV PERIOD CLINICAL LABOR TIME (RN)	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0
15	PRE-SERVICE						
16	Start: Following visit when decision for surgery or procedure made						
17	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3		3	
18	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3	
19	Schedule space and equipment in facility	L037D	RN/LPN/MTA				
20	Provide pre-service education/obtain consent						
21	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3	
22	Other Clinical Activity (please specify): Retrieve prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocal with interpreting MD	L041B	RT	6		6	
23	End:When patient enters office/facility for surgery/procedure						
24	SERVICE PERIOD						
25	Start: When patient enters office/facility for surgery/procedure						
26	Pre-service services						
27	Review charts	L037D	RN/LPN/MTA	2		2	
28	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
29	Obtain vital signs	L051A	RN/LPN/MTA	5		5	
30	Provide pre-service education/obtain consent	L051A	RN/LPN/MTA	3		3	
31							
32	Prepare room, equipment, supplies						
33	Prepare room, equipment, supplies	L041B	RT	2		2	
34	Setup scope (non facility setting only)						
35	Prepare and position patient/ monitor patient	L041B	RT	2		2	
36	Sedate/apply anesthesia	L051A	RN	2		2	
37	Intra-service						
38	Assist physician in performing procedure	L041B	RT	28		15	
39	Assist physician MCS monitoring. Assist physician MCS monitoring	L051A	RN				
40	Assist physician with image acquisition performing procedure	L041B	RT	18		10	
41	Post-Service						
42	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		15	
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
44	Clean room/equipment by physician staff						
45	Clean Scope						
46	Clean Surgical Instrument Package						
47	Complete diagnostic forms, lab & X-ray requisitions						
48	Review/read X-ray, lab, and pathology reports						
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN/LPN/MTA	3		3	
50	Discharge day management 99238 --12 minutes 99239 --15 minutes						
51	Other Clinical Activity (please specify): post procedure image processing		RT	3		3	
52	End: Patient leaves office						
53	POST-SERVICE Period						
54	Start: Patient leaves office/facility						
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	0	0	0
56	*Office visits*						
57	*List Number and Level of Office Visits*						
58	99211 16 minutes		16				
59	99212 27 minutes		27				
60	99213 36 minutes		36				
61	99214 53 minutes		53				
62	99215 63 minutes		63				
63	Other						
64	*Total Office Visit Time*			0	0	0	0
65	Other Activity (please specify)						
66	End: with last office visit before end of global period						

	A	B	C	P	Q	R	S
1	April 2007			49452		49460	
2	AMA/Specialty Society RVS Update Committee Recommendation			Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report		Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
67	MEDICAL SUPPLIES	CMS Code	Unit				
68	pack, EM visit	SA047	pack	1		1	
69	pack, conscious sedation	SA044	pack				
70	additional sterile gloves	SB024	item	2		2	
71	lidocaine	SH047	ml	20		20	
72	needle 25 G	SC049	item	4		4	
73	saline flush syringe	SH065	item	2		4	
74	needle , 18 G	SC029	item	1		1	
75	guidewire, steerable (Transcend)	SD175	item	1		1	
76	guidewire, stiff	SD090	item	1		1	
77	guidewire, steerable (Hi Torque)	SD174	item			1	
78	guidewire, torque	SD176	item			1	
79	dilators 6-Fand 20-F	SD043	item	2		2	
80	sheath, peel away	SD206	item	1		1	
81	kit, guidewire introducer (Micro-Stick)	SA016	item	1		1	
82	gastrostomy tube	NEW	item	1			
83	jejunostomy	NEW	item	1			
84	x-ray ID card (flashcard)	SK093	item	1		1	
85	film, x-ray 14 inx17in	SK034	item	2		2	
86	x-ray envelope	SK091	item	1		1	
87	x-ray developer solution	SK089	oz	2		2	
88	x-ray fixer solution	SK092	oz	2		2	
89	disinfectnat, surface (Envirocide, Sanizide)	SM013	oz	1		1	
90	computer media, dvd	SK013	item	1		1	
91	drape sterile, c-arm fluoro	SB008	item	1		1	
92							
93	Equipment	CMS Code	Unit				
94	Angio suite	EL011		1		1	
95	pulse oximeter	EQ211					
96	ECG, 3-channel (with Sp02, NIBR)	EQ011					
97	film alternator	ED024		1		1	
98	Film printer laser	ED032		1		1	
99	stretcher	EF018		1		1	
100	Infusion pump	EQ032					
101	oxygen tank						
102							

	A	B	C	T	U
1	April 2007			49465	
2	AMA/Specialty Society RVS Update Committee Recommendation			Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			000	000
5	TOTAL CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	25.0	0.0
6	TOTAL CLINICAL LABOR TIME (Angio Tech)	L041B	RT	29.0	0.0
7	TOTAL CLINICAL LABOR TIME (RN)	L051A	RN	2.0	0.0
8	PRE-SERV CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	9.0	0.0
9	PRE-SERV CLINICAL LABOR TIME (ANGIO Tech)	L041B	RT	6.0	0.0
10	SERVICE PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	16.0	0.0
11	SERVICE PERIOD CLINICAL LABOR TIME (ANGIO tech)	L041B	RT	23	0
12	SERVICE PERIOD CLINICAL LABOR TIME (RN)	L051A	RN	2	0
13	POST-SERV PERIOD CLINICAL LABOR TIME (RN/LPN/MTA)	L037D	RN/LPN/MTA	0.0	0.0
14	POST-SERV PERIOD CLINICAL LABOR TIME (RN)	L037D	RN/LPN/MTA	0.0	0.0
15	PRE-SERVICE				
16	Start: Following visit when decision for surgery or procedure made				
17	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	
18	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	
19	Schedule space and equipment in facility	L037D	RN/LPN/MTA		
20	Provide pre-service education/obtain consent				
21	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	
22	Other Clinical Activity (please specify): Retreive prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocal with interpreting MD	L041B	RT	6	
23	End:When patient enters office/facility for surgery/procedure				
24	SERVICE PERIOD				
25	Start: When patient enters office/facility for surgery/procedure				
26	Pre-service services				
27	Review charts	L037D	RN/LPN/MTA	2	
28	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
29	Obtain vital signs	L051A	RN/LPN/MTA	5	
30	Provide pre-service education/obtain consent	L051A	RN/LPN/MTA	3	
31					
32	Prepare room, equipment, supplies				
33	Prepare room, equipment, supplies	L041B	RT	2	
34	Setup scope (non facility setting only)				
35	Prepare and position patient/ monitor patient	L041B	RT	2	
36	Sedate/apply anesthesia	L051A	RN	2	
37	Intra-service				
38	Assist physician in performing procedure	L041B	RT	8	
39	Assist physician MCS monitoring. Assist physician MCS monitoring	L051A	RN		
40	Assist physician with image acquisition performing procedure	L041B	RT	8	
41	Post-Service				
42	Monitor pt.,following service/check tubes, monitors, drains.	L051A	RN		
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA		
44	Clean room/equipment by physician staff				
45	Clean Scope				
46	Clean Surgical Instrument Package				
47	Complete diagnostic forms, lab & X-ray requisitions				
48	Review/read X-ray, lab, and pathology reports				
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN/LPN/MTA	3	
50	Discharge day management 99238 --12 minutes 99239 --15 minutes				
51	Other Clinical Activity (please specify): post procedure image processing		RT	3	
52	End: Patient leaves office				
53	POST-SERVICE Period				
54	Start: Patient leaves office/facility				
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	0
56	*Office visits:*				
57	*List Number and Level of Office Visits*				
58	99211 16 minutes		16		
59	99212 27 minutes		27		
60	99213 36 minutes		36		
61	99214 53 minutes		53		
62	99215 63 minutes		63		
63	Other				
64	*Total Office Visit Time*			0	0
65	Other Activity (please specify)				
66	End: with last office visit before end of global period				

	A	B	C	T	U
1	April 2007			49465	
2	AMA/Specialty Society RVS Update Committee Recommendation			Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including Imago documentation and report	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
67	MEDICAL SUPPLIES	CMS Code	Unit		
68	pack, EM visit	SA047	pack	1	
69	pack, conscious sedation	SA044	pack		
70	additional sterile gloves	SB024	item	2	
71	lidocaine	SH047	ml		
72	needle 25 G	SC049	item	1	
73	saline flush syringe	SH065	item	1	
74	needle , 18 G	SC029	item	1	
75	guidewire, steerable (Transcend)	SD175	item		
76	guidewire, stiff	SD090	item		
77	guidewire, steerable (Hi Torque)	SD174	item		
78	guidewire, torque	SD176	item		
79	dilators 6-Fand 20-F	SD043	item		
80	sheath, peel away	SD206	item		
81	kit, guidewire introducer (Micro-Stick)	SA016	item		
82	gastrostomy tube	NEW	item		
83	jejunostomy	NEW	item		
84	x-ray ID card (flashcard)	SK093	item	1	
85	film, x-ray 14 inx17in	SK034	item	2	
86	x-ray envelope	SK091	item	1	
87	x-ray developer solution	SK089	oz	2	
88	x-ray fixer solution	SK092	oz	2	
89	disinfectnat, surface (Envirocide, Sanizide)	SM013	oz	1	
90	computer media, dvd	SK013	item	1	
91	drape sterile, c-arm fluoro	SB008	item	1	
92					
93	Equipment	CMS Code	Unit		
94	Angio suite	EL011		1	
95	pulse oximeter	EQ211			
96	ECG, 3-channel (with Sp02, NIBR)	EQ011			
97	film alternator	ED024		1	
98	Film printer laser	ED032		1	
99	stretcher	EF018		1	
100	Infusion pump	EQ032			
101	oxygen tank				
102					

	A	B	C	D	E
1				43760	
2	American Gastroenterological Association American Society for Gastrointestinal Endoscopy			Code Descriptor Change of Gastrostomy Tube	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME	L037B	RN/LPN/MTA	31.0	3.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037B	RN/LPN/MTA	0.0	3.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037B	RN/LPN/MTA	28.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037B	RN/LPN/MTA	3.0	0.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037B	RN/LPN/MTA		
12	Coordinate pre-surgery services	L037B	RN/LPN/MTA		
13	Schedule space and equipment in facility	L037B	RN/LPN/MTA		3
14	Provide pre-service education/obtain consent	L037B	RN/LPN/MTA		
15	Follow-up phone calls & prescriptions	L037B	RN/LPN/MTA		
16	Other Clinical Activity (please specify)				
17	End:When patient enters office/facility for surgery/procedure				
18	SERVICE PERIOD				
19	Start: When patient enters office/facility for surgery/procedure				
20	Pre-service services				
21	Review charts				
22	Greet patient and provide gowning	L037B	RN/LPN/MTA	3	
23	Obtain vital signs	L037B	RN/LPN/MTA	3	
24	Provide pre-service education/obtain consent	L037B	RN/LPN/MTA	5	
25	Prepare room, equipment, supplies	L037B	RN/LPN/MTA	2	
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L037B	RN/LPN/MTA	2	
28	Sedate/apply anesthesia				
29	Intra-service				
30	Assist physician in performing procedure	L037B	RN/LPN/MTA	7	
31	Post-Service				
32	Monitor pt. following service/check tubes, monitors, drains	L037B	RN/LPN/MTA		
33	Clean room/equipment by physician staff	L037B	RN/LPN/MTA	3	
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate	L037B	RN/LPN/MTA	3	
39	Discharge day management 99238 --12 minutes	99239 --15 minutes			
40	Other Clinical Activity (please specify)				
41	End: Patient leaves office				
42	POST-SERVICE Period				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions	L037B	RN/LPN/MTA	3	
45	*List Number and Level of Office Visits*				
46	99211 16 minutes		16		
47	99212 27 minutes		27		
48	99213 36 minutes		36		
49	99214 53 minutes		53		
50	99215 63 minutes		63		
51	*Total Office Visit Time*			0	0
53	End: with last office visit before end of global period				
54	MEDICAL SUPPLIES	CMS Code	Unit		
55	pack, minimum multi-specialty visit	SA048	item	1	
56	gown, surgical, sterile	SB028	item	2	
57	gloves, sterile	SB024	item	2	
58	mask, surgical, with face shield	SB034	item	2	
59	cap, surgical	SB001	item	2	
60	shoe covers, surgical	SB039	item	2	
61	drape, sterile, fenestrated 16in x 29in	SB011	item	1	
62	drape-towel, sterile 18inx26in	SB019	item	2	
63	kit, suture removal	SA031	item	1	
64	tray, shave prep	SA067	item	1	
65	underpad 2ftx3ft (Chux)	SB044	item	1	
66	povidone soln (Betadine)	SJ041	cc	60	
67	applicator, sponge-tipped	SG009	item	4	
68	lidocaine 1%-2% inj (Xylocaine)	SH047	cc	10	
69	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2	
70	3 way stop cock (for irrigation)	SC049	item	1	
71	syringe 60ml (for irrigation)	SC056	item	2	
72	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1	
73	closed flush system, angiography	SC010	item	1	
74	sodium chloride 0.9% flush syringe	SH065	item	2	
75	catheter, drainage (Flexima)	SD161	item	1	
76	guidewire	SD088	item	1	
77	gauze, sterile 4in x 4in	SG055	item	6	
78	tape, surgical paper 1in (Micropore)	SG079	item	12	
79	low profile gastrostomy replacement button	See invoice	item	1	
80	stoma measuring device	See invoice	item	1	
81	Equipment	CMS Code	Util.%		
82	Exam table	EF03	100%	10	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Transurethral Ureteral Stent Tube Exchange and Removal

The CPT Editorial Panel created two new codes to accurately describe the removal or removal and exchange of a ureteral stent, using radiological guidance methods.

50385

The RUC reviewed the specialty society survey median RVU and physician time for code 50385 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation.* The specialty society indicated that the key reference service, code 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (work RVU=5.50, 50 minutes pre-, 60 minutes intra-, and 15 minutes post-service time), has more physician time involved, however the intensity of the two procedures is very similar. The specialty society indicated that the survey median RVU for 50385 was too high and recommend a building block approach to develop an RVU of 4.44.

The building block RVU is calculated by taking the reference service code's intra-service intensity measure of 0.06978, multiplied to the intra-service time of 45 minutes for code 50385 (0.07 x 45 = 3.15). Then add the pre-service (29 minutes evaluation, 10 minutes positioning and 10 minutes scrub, dress, wait = 49 minutes) and post-service (15 minutes) RVUs (0.95+0.34) to intra service RVU (3.15) to establish a total work RVU of 4.44 for 50385.

Additional reference service codes with comparable physician intra-service time and work RVUs are 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (RVU=5.20, 43 minutes intra-service) and 36360 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age* (RVU=6.26, intra-service time 45 minutes). The RUC determined this aforementioned building block approach along with the additional reference services supported a work RVU of 4.44, which is below the survey 25th percentile. **The RUC recommends a work RVU of 4.44 for code 50385.**

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50386
The RUC reviewed the survey median RVU and physician time for code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation.* The specialty society indicated that the key reference service, code 50384 *Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (work RVU=5.00, 55 minutes intra-service) has more physician time and intensity than 50386. The specialty society indicated that the survey median RVU of 5.00 for 50386 was too high and recommend a building block approach to develop a recommended work RVU of 3.30.

The building block RVU is calculated by taking the reference service code's intra-service intensity measure of 0.07029, multiplied to the intra-service time of 30 minutes for 50386 (0.07 x 30 = 2.10). Then add the pre-service (25 minutes evaluation, 10 minutes positioning and 10 minutes scrub, dress, wait = 45 minutes) and post-service (15 minutes) RVUs (0.87+0.33) to intra service RVU (2.10) to establish a total work RVU of 3.30 for 50386.

Additional reference service codes with comparable physician intra-service time and work RVUs are 36581 *Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (RVU=3.45, 30 minutes intra-service) and 36590 *Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion* (RVU=3.32, 30 minutes intra-service). The RUC determined the aformentioned building block approach along with the additional reference services supported a work RVU of 3.30. **The RUC recommends a work RVU of 3.30 for code 50386.**

Practice Expense
The PERC and RUC reviewed and refined the joint specialty recommendation for the direct inputs for codes 50385 and 50386 during its February 2007 meeting. **The RUC recommends the attached direct practice expense inputs.**

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
⊙ ● 50385	G1	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	000	4.44
⊙ ● 50386	G2	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	000	3.30

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:50385 Tracking Number G1 Specialty Society Recommended RVU: **4.44**
Global Period: 000 RUC Recommended RVU: **4.44**

CPT Descriptor: Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female has an indwelling nephroureteral double-J stent tube in place, treating a ureteral obstruction caused by a stricture from post-operative and post-radiation scarring as a result of treatment of transitional cell cancer. The stent tube requires exchange every three months to prevent occlusion of the stent and subsequent urinary tract infection and loss of function of the ipsilateral kidney.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:
The physician:
- Sees the patient in the interventional suite and briefly examines
- Reviews prior imaging studies and other test results
- Obtains a brief history assuring that there has been no intercurrent changes or complaints
- Discusses the procedure with the patient and family and informed consent is obtained for retrieval and replacement of the ureteral stent
- Supervises staff establishing an intravenous site and places the patient in a supine position on the table
- Confirms proper room set up including sterile preps and drapes and selects appropriate devices such as catheters, sheaths, guidewires, and ureteral stents
- Proper positioning of the patient on the radiologic table is confirmed with sterile prep and drape of the urethra performed

Description of Intra-Service Work:
The physician:
- Orders medication for conscious sedation
- A 4-Fr diagnostic catheter is advanced into the bladder, and contrast is injected to opacify the bladder and to identify relevant anatomy
- A guidewire is advanced into the bladder, and the diagnostic catheter is exchanged for a larger catheter, which allows introduction of a snare device
- Under fluoroscopic guidance, a snare device is negotiated into the bladder through the sheath and used to grasp the pigtail portion of the double-J ureteral stent tube within the bladder, and the indwelling stent tube is pulled out of the bladder and urethra far enough to allow retrograde introduction of a guidewire through the stent, directed into the renal pelvis
- Fluoroscopic guidance is used to negotiate the wire through the inner lumen of the ureteral stent tube rather than through the sideholes
-The indwelling double-J stent is removed via the urethra over the guidewire
- A diagnostic catheter is positioned over the wire into the renal pelvis, allowing opacification of the renal pelvis if the renal pelvis was not opacified by the bladder injection
-The guidewire is then re-positioned into the renal pelvis, and the diagnostic catheter removed

- A new double-J ureteral stent tube is then introduced over the wire, placed and positioned with the proximal pigtail in the renal pelvis and the distal pigtail in the bladder, and the wire is removed (If balloon dilation of the ureter is necessary for stent passage this is separately reportable)
- Appropriate position is confirmed with fluoroscopy, and permanent image(s) are obtained for the medical record
- The guide/sheath/safety wire are removed
- Images are obtained documenting final stent position

Description of Post-Service Work:
- A note is made in the patient record and orders are written
- Oversees the transfer of the patient to the recovery unit
- Notifies the referring physician of the outcome of the procedure, and of subsequent procedures to be done
- Discusses the outcome of the procedure with the patient and family and instructions are given
- Dictates a report for the permanent record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Robert L. Vogelzang, MD Geraldine McGinty, MD					
Specialty(s):	Society of Interventional Radiology and American College of Radiology					
CPT Code:	50385					
Sample Size:	450	**Resp N:**	33	**Response:** 7.3 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**4.00**	12.50	100.00
Survey RVW:		3.50	5.30	**5.50**	5.75	7.02
Pre-Service Evaluation Time:				**29**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		15.00	30.00	**45.00**	50.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 50385	
	Specialty Recommended
Physician Work RVU:	4.44
Pre-Service Evaluation Time:	29.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	10.0
Intra-Service Time:	45.00
Immediate Post Service-Time:	15.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50382	000	5.50	RUC Time

CPT Descriptor Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 72.7 %

TIME ESTIMATES (Median)

	CPT Code: 50385	Key Reference CPT Code: 50382	Source of Time RUC Time
Median Pre-Service Time	48.50	50.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**108.50**	**125.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.52	2.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.92
Urgency of medical decision making	2.21	2.29

Technical Skill/Physical Effort (Mean)

Technical skill required	3.77	3.83
Physical effort required	2.98	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.90	3.25
Outcome depends on the skill and judgment of physician	3.65	3.63

Estimated risk of malpractice suit with poor outcome	2.75	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.77	2.67
Intra-Service intensity/complexity	3.56	3.54
Post-Service intensity/complexity	2.58	2.50

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Societies' recommended work RVU value was calculated based on the reference service intensity measure of 0.07, which was previously deliberated and assigned by the RUC in development of a work RVU value for the reference service code 50382.

Applying an intensity of 0.07 to the intra-service time of 45 minutes, yields an intra-service RVU value of 3.15. Adding pre- (0.9434) and post- (0.336) RVU values, calculated using standard RUC formulas, supports a total work RVU recommendation of 4.43 RVUs.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Same day preceding diagnostic studies may indicate a need for intervention earlier than typically scheduled resulting in immediate conversion to this therapuetic procedure.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A common diagnostic study that may precede the performance of a transuretheral ureteral stent

exchange is a cystogram which is reported using codes 51600 and 74430. The diagnostic study may be performed by the same or a different provider from the interventionalist performing the ureteral stent exchange procedure. Code 51600- global period 000, work RVUs 0.88, pre-service time 20 minutes, intra-service time 20 minutes, post-service time 15 minutes (RUC times). Code 74430- global period XXX with 8 minutes total time (Harvard).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

If the removal/exchange of the stent is transurethral and performed without cystoscopy, the following cystourethroscopy codes have been used:

53899, unlisted urologic procedure

Additionally, the radiological supervision and interpretation (S&I) code 75984 is used to report the imaging services provided in conjunction with the removal and placement of the ureteral stent:
75984 Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology, Interventional Radiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Radiology, Interventiona Radiology Frequency 500 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 350
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Radiology, Interventional Radiology Frequency 350 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:50386 Tracking Number G2 Specialty Society Recommended RVU: **3.30**
Global Period: 000 RUC Recommended RVU: **3.30**

CPT Descriptor: Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30 year old female has an indwelling ureteral double-J stent tube in place to allow healing of a ureteral injury occurring at the time of an emergency c-section. The stent is now ready to be removed. The injury is healed, and diversion is no longer required.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 96%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:
The physician:
- Sees the patient in the interventional suite and briefly examines
- Reviews prior imaging studies and other test results
- Obtains a brief history assuring that there has been no intercurrent changes or complaints
- Discusses the procedure with the patient and family and informed consent is obtained for retrieval of the ureteral stent
- Supervises staff establishing an intravenous site and places the patient in a supine position on the table
- Confirms proper room set up including sterile preps and drapes and selects appropriate devices such as catheters, snare device, sheaths, and guidewires
- Proper positioning of the patient on the radiologic table is confirmed with sterile prep and drape of the urethra performed

Description of Intra-Service Work:
The physician
- Orders medication for conscious sedation
- A 4-Fr diagnostic catheter is advanced into the bladder, and contrast is injected to opacify the bladder and to identify relevant anatomy
- A guidewire is advanced into the bladder, and the diagnostic catheter is exchanged for a larger catheter, which allows introduction of a snare device
- Under fluoroscopic guidance, a snare device is negotiated into the bladder through the sheath and used to grasp the pigtail portion of the double-J ureteral stent tube within the bladder, ureteral stent tube is completely removed through the urethra
- Complete removal is confirmed with fluoroscopy, and permanent image(s) are obtained for the medical record
- The guide/sheath/safety wire are removed
- Appropriate position is confirmed with fluoroscopy, and permanent image(s) are obtained for the medical record

Description of Post-Service Work:
The physician
- Makes a note in the patient record and orders are written
- Oversees the transfer of the patient to the recovery unit
- Notifies the referring physician of the outcome of the procedure, and of subsequent procedures to be done
- Discusses the outcome of the procedure with the patient and family and instructions are given
- Dictates a report for the permanent record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Robert L. Vogelzang, MD Geraldine McGinty, MD				
Specialty(s):	Society of Interventional Radiology and American College of Radiology				
CPT Code:	50386				
Sample Size: 450	**Resp N:** 33	**Response:** 7.3 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**3.00**	8.25	100.00
Survey RVW:	2.00	4.80	**5.00**	5.02	6.00
Pre-Service Evaluation Time:			**25.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	10.00	20.00	**30.00**	45.00	120.00
Immediate Post Service-Time:	**15.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 50386		
		Specialty Recommended
Physician Work RVU:		**3.30**
Pre-Service Evaluation Time:		**25.0**
Pre-Service Positioning Time:		**10.0**
Pre-Service Scrub, Dress, Wait Time:		**10.0**
Intra-Service Time:		**30.00**
Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50384	000	5.00	**RUC Time**

CPT Descriptor Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 1				
MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 2				

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 84.8 %

TIME ESTIMATES (Median)

	CPT Code: 50386	Key Reference CPT Code: 50384	Source of Time RUC Time
Median Pre-Service Time	45.00	35.00	
Median Intra-Service Time	30.00	55.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**90.00**	**105.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.46	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.55	2.68
Urgency of medical decision making	2.21	2.43

Technical Skill/Physical Effort (Mean)

Technical skill required	3.45	3.50
Physical effort required	3.04	3.04

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.55	2.89
Outcome depends on the skill and judgment of physician	3.07	3.18

Estimated risk of malpractice suit with poor outcome	2.81	2.92

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.35	2.44
Intra-Service intensity/complexity	3.22	3.30
Post-Service intensity/complexity	2.35	2.44

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Societies' recommended work RVU value was calculated based on the reference service intensity measure of 0.07, which was previously deliberated and assigned by the RUC in development of a work RVU value for the reference service code 50384.

Applying an intensity of 0.07 to the intra-service time of 30 minutes, yields an intra-service RVU value of 2.1. Adding pre- (0.865) and post- (0.336) RVU values, calculated using standard RUC formulas, supports a total work RVU recommendation of 3.30 RVUs.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Same day preceding diagnostic studies may indicate a need for intervention earlier than typically scheduled resulting in immediate conversion to this therapuetic procedure.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A common diagnostic study that may precede the performance of a transuretheral ureteral stent exchange is a cystogram which is reported using codes 51600 and 74430. The diagnostic study may be

performed by the same or a different provider from the interventionalist performing the ureteral stent removal procedure. Code 51600- global period 000, work RVUs 0.88, pre-service time 20 minutes, intra-service time 20

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) If the removal of the stent is transurethral and performed without cystoscopy, the following cystourethroscopy codes have been used:

53899, unlisted urologic procedure

Additionally, the radiological supervision and interpretation (S&I) code 75984 is used to report the imaging services provided in conjunction with the removal and placement of the ureteral stent:
75984 Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretatio

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology, Interventional Radiology How often? Sometimes

Specialty Radiology, Interventional Radiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Radiology, Interventional Radiology Frequency 400 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 325
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Radiology, Interventional Radiology Frequency 325 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

	A	B	C	D	E	F	G
1	RUC Recommendation						
2	Feb-07			CPT Code: 50385		CPT Code: 50386	
3				Code Descriptor: Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach		Code Descriptor: Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME			182.0	26.0	142.0	26.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			15.0	23.0	15.0	23.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			164.0	0.0	124.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	3.0	3.0	3.0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2	5	2	5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10	3	10
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	3	5	3	5
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5	
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	2	3	2	3
17	Other Clinical Activity (please specify)						
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure						
21	Pre-service services						
22	Review charts	L037D	RN/LPN/MTA	2		2	
23	Retrieve prior imaging exams and hang for MD review, verify orders, review chart to incorporate relevant clinical information and confirm contrast protocal with interpreting MD	L037D	RN/LPN/MTA				
24	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
25	Obtain vital signs	L037D	RN/LPN/MTA	5		5	
26	Provide pre-service education/obtain consent						
27	Provide pre-service education/obtain consent for contrast administration						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
29	Prepare room, equipment, supplies for imaging	L037D	RN/LPN/MTA	2		2	
30	Setup scope (non facility setting only)						
31	Prepare and position patient/ monitor patient/ set up IV	L051A	RN	2		2	
32	Intra-service						
33	Sedate/apply anesthesia: Assist physician MCS monitoring	L051A	RN	45		30	
34	Assist physician in performing procedure	L041B	RT	30		20	
35	Assist physician with image acquisition during procedure	L041B	RT	45		30	
36	Post-Service						
37	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		15	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
39	Clean imaging equipment by physician staff	L041B	RT	2		2	
40	Clean Scope						
41	Clean Surgical Instrument Package						
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	3		3	
43	Review/read X-ray, lab, and pathology reports						
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
45	Discharge day management 99238 –12 minutes 99239 –15 minutes						
46	Other Clinical Activity (please specify): post procedure image processing	L041B	RT	2		2	
47	End: Patient leaves office						
48	POST-SERVICE Period						
49	Start: Patient leaves office/facility						
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
51	*Office visits:* re						
52	*List Number and Level of Office Visits*						
53	99211 16 minutes		16				
54	99212 27 minutes		27				
55	99213 36 minutes		36				
56	99214 53 minutes		53				
57	99215 63 minutes		63				
58	Other						
59	*Total Office Visit Time*			0	0	0	0
60	Other Activity (please specify)						
61	End: with last office visit before end of global period						

	A	B	C	D	E	F	G
2	Feb-07			CPT Code: 50385		CPT Code: 50386	
3				Code Descriptor: Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach		Code Descriptor: Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
62	MEDICAL SUPPLIES	CMS Code	Unit				
63							
64	minimum supply pack			1		1	
65	x-ray envelope	SK091		1		1	
66	Gown, surgical, stenle	SB028		2		2	
67	Film, x-ray14 in x 17in	SK034		1		1	
68	x-ray developer solution	SK089		0.5		0.5	
69	x-ray fixer solution	SK092		0.5		0.5	
70	disinfectant, surface (Envirocide)	SM013		1		1	
71	computer media, dvd	SK013		1		1	
72	mask, surgical with face sheild	SB034		2		2	
73	cap, surgical	SB001		2		2	
74	drape, stenle, fenestrated 16in x 29in	SB011		1		1	
75	gloves, stenle	SB024		2		2	
76	drape-towel, sterile 18in x 26in	SB019		2		2	
77	shoe covers, surgical	SB039		2		2	
78	pack, conscious sedation	SA044		1		1	
79	syringe w-needle, OSHA compliant (SaftyGlide)	SC058		2		2	
80	catheter percutaneous fastner (Percu-Stay)	SD146		1		1	
81	Foley catheter			1		1	
82	underpad 2ft x 3ft (Chux)	SB044		1		1	
83	closed flush system, angiography	SC010		1		1	
84	Angled tip Glidewire (Terumo) 180 cm	NEW		1		1	
85	Amplatz superstiff guidewire, 300 cm Boston Scientific	NEW		1		1	
86	Amplatz Nitinol snare	NEW		2		2	
87	Kumpe catheter	NEW		1		1	
88	tape, surgical paper 1 in (Micropore)	SG079		12		12	
89	gauze, sterile 4in x 4 in	SG055		6		6	
90	sodium chloride, 0.9% flush syringe	SH065		4		4	
91	stop cock, 3-way	SC049		1		1	
92	povidone soltion (Betadine)	SJ041		60		60	
93	syringe 50-60 ml	SC056		2		2	
94	drainage catheter, all purpose	SD161		1		1	
95	tray, shave prep	SD067		1		1	
96	internal ureteral stent 8 french - Boston Scientific	SD218		1			
97							
98							
99							
100	Equipment	CMS Code	Utilization Percentage				
101	ECG, 3-channel	EQ011		1		1	
102	pulse oximeter w-printer	EQ211		1		1	
103	light, exam	EQ168		1		1	
104	stretcher chair	EF019		1		1	
105	film alternator	ER029		1		1	
106	room, angiography	EL011		1		1	
107	film processor, dry, laser	ED024		1		1	
108	infusion pump			1		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Intra-Abdominal Voiding Pressure - Update

The CPT Editorial Panel changed CPT code, 51797, *Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)*, from a stand-alone service to an add-on service. The Panel agreed that the service should be an add-on service as it is virtually always performed with CPT code, 51795, *Voiding pressure studies (VP); bladder voiding pressure, any technique*, (work RVU = 1.53). The intra-abdominal voiding pressure is performed after the bladder study during the same session and involves inserting a rectal catheter and performing an additional calculation.

1275

February 2007
The RUC considered the specialty society's recommendations for code 51797. While this service is currently valued at 1.60 work RVUs, when it is performed in combination with code 51795, the service is subject to the multiple procedure reduction of 50% and valued appropriately at 0.80 work RVUs (1.60 x 50% = 0.80). The specialty society has recommended a work RVU of 1.00 based on a survey of 32 urologists. The RUC informed the specialty society that if it wishes to recommend a work RVU different than 0.80, it must provide compelling evidence to do so. The RUC requested that the specialty provide its recommendation and rationale, including compelling evidence for a change, if warranted, at the April 2007 RUC meeting. The RUC did, however, provide a direct practice expense input in February 2007.

April 2007
At the April 2007 RUC meeting, the specialty society accepted the RUC's recommendation to maintain the appropriate value of 0.80 work RVUs for 51797. The society agreed that there was not compelling evidence to review the work and agreed that the service should be valued at 0.80 work RVUs to maintain its present value of 1.60 work RVU x 50% multiple procedure reduction (0.80). **The RUC recommends a work RVU of 0.80 for code 51797 consistent with its current valuation accounting for the multiple procedure reduction.**

Practice Expense
The RUC recommends the non-facility practice inputs as amended for this ZZZ procedure.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲+51797	H1	Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal) (List separately in addition to primary procedure 51795) (Use code 51797 in addition to 51795)	~~XXX~~ ZZZ	0.80

1276

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American
Urological
Association

April 3, 2007

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RVS Update Committee
Relative Value Systems
American Medical Association
515 North State Street
Chicago, IL 60610

RE: Request for Reconsideration of Work RVU Recommendation for 51797 (Intra-abdominal Voiding Pressure)

Dear Dr. Rich:

In follow-up to the February 2007 RUC meeting where we presented to the RUC our median RUC survey RVW of 1.00, we understand that as this is an add-on procedure to 51795, compelling evidence would need to be presented in order to justify a work RVU above 0.80.

We concur with the RUC's recommendation on this issue per the RUC minutes and will accept the RUC's recommended work RVU of 0.80.

Thank you for your understanding on this issue.

Sincerely,

James Giblin, MD
AUA RUC Advisor

cc: James Regan, MD, RUC Member, AUA Health Policy Council Chair
Thomas Cooper, RUC Alternate
Roger Dmochowski, MD, SUFU President
Nancy K. Edwards, AUA Director of Reimbursement& Regulatory Affairs
Sherry Smith, Director, AMA/Specialty Society RVS Update Committee

Headquarters

Mr. Michael T. Sheppard, C.P.A., C.A.E.
Executive Director

1000 Corporate Boulevard
Linthicum, MD 21090

U.S. Toll Free: **1-866-RING-AUA**
(1-866-746-4282)
Phone: 410-689-3700
:: 410-689-3800
.nail: aua@auanet.org
Web sites: www.auanet.org
www.AUAFoundation.org
www.UrologyHealth.org
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AUA 2007
ANNUAL MEETING
ANAHEIM, CA NOV 19-24, 2007
www.aua2007.org

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:51797 Tracking Number 2807PA Specialty Society Recommended RVU: **0.80**
Global Period: ZZZ RUC Recommended RVU: **0.80**

CPT Descriptor: Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59 year-old female with multiple sclerosis complains of three year history of urinary frequency, urgency and incontinence and the sensation of incomplete emptying. She is currently wearing two pads a day. She is currently taking Ditropan for her voiding complaints. A post void residual measured in the office was 250 mls, a urine culture was negative.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After standard detrusor pressure is documented (reported separately using 51795), the physician inserts a rectal transducer into the rectum to record intra-abdominal pressure. The inflow tubing is connected, flushed and secured and all electronic equipment recalibrated. Pressure transduction testing is necessary prior to onset of the examination (usually with serial coughing). This is an interactive examination between patient and examiner. Multiple fills are usually necessary to accurately assess and record intra-abdominal pressure. The physician calculates and interprets the abdominal pressure recorded versus the total intravesical pressure and records the true intravesical pressure during voiding.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	James Giblin, M.D., Michael Albo, M.D.				
Specialty(s):	Urology				
CPT Code:	51797				
Sample Size: 79	**Resp N:** 32	**Response:** 40.5 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	5.00	20.00	**100.00**	300.00	500.00
Survey RVW:	1.00	1.00	**1.00**	2.00	4.00
Pre-Service Evaluation Time:			**12.5**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	5.00	10.00	**15.00**	26.25	45.00
Immediate Post Service-Time:	**8.00**				

CPT Code: 51797

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 51797	
	Specialty Recommended
Physician Work RVU:	**0.80**
Pre-Service Evaluation Time:	**0.0**
Pre-Service Positioning Time:	**0.0**
Pre-Service Scrub, Dress, Wait Time:	**0.0**
Intra-Service Time:	**15.00**

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
51795	000	1.53	**RUC Time**

CPT Descriptor Voiding pressure studies (VP); bladder voiding pressure, any technique

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
13133	ZZZ	8,183	2.19	**RUC Time**

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99213	XXX	111,261,211	0.67	**RUC Time**

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the

presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 62.5 %

TIME ESTIMATES (Median)	CPT Code: 51797	Key Reference CPT Code: 51795	Source of Time RUC Time
Median Pre-Service Time	0.00	20.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	0.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**15.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.30
Urgency of medical decision making	2.80	2.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.05	2.85
Physical effort required	2.80	2.65
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.85	1.75

Outcome depends on the skill and judgment of physician	3.00	2.90
Estimated risk of malpractice suit with poor outcome	1.95	1.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.50
Intra-Service intensity/complexity	3.00	2.75
Post-Service intensity/complexity	2.75	2.75

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel of urologists with representation from both academic and private practice reviewed the survey data and concurred that the proposed RVW of 1.00 was appropriate. The panel also concurred that both the pre-service and post-service survey times should not be included in 51797 as pre and post time is adequately captured in the base code 51795.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 51797

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty OB-GYN How often? Sometimes

Specialty Family Practitioners How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 170000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 103,063 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).

AMA/Specialty Society Update Process
PERC Summary of Recommendation
ZZZ Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)

Sample Size:_____ Response Rate: (%):_____ Global Period: zzz

Geographic Practice Setting %: Rural 0 Suburban 31.25 Urban 68.75

Type of Practice %:
- 6.25 Solo Practice
- 37.5 Single Specialty Group
- 12.5 Multispecialty Group
- 43.75 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: Our practice expense recommendations are based on the deliberation of a panel of urologists from various geographic and practice settings, including from private and academic practices.

Please describe the clinical activities of your staff:
Intra-Service Clinical Labor Activities:
Assist physician in performing procedure. (RN, LPN, etc)
Check dressings and wound/home care instructions/coordinate office visits/prescriptions

	A AMA Specialty Society Recommendation		C	D	E
1				CPT Code 51797	
2				Proposed Times & Inputs	
3	April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Code Descriptor: Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	Global Period	L037D	RN/LPN/MA	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			10.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			10.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
10	PRE-SERVICE				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity (please specify)				
18	**End:When patient enters office/facility for surgery/procedure**				
19	SERVICE PERIOD				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning				
24	Obtain vital signs				
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies				
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV				
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure	L037D	RN/LPN/MA	10	
32	**Post-Service**				
33	Monitor pt. following service/check tubes, monitors, drains				
34	Clean room/equipment by physician staff				
35	Clean Scope				
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
40	Discharge day management 99238 --12 minutes 99239 --15 minutes				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				
43	POST-SERVICE Period				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	*Office visits:*				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54					
55	*Total Office Visit Time*				
56					
57	Other Activity (please specify)				
58	**End: with last office visit before end of global period**				

	A AMA Specialty Society Recommendation		C	D	E
1				CPT Code 51797	
2				Proposed Times & Inputs	
3	April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Code Descriptor: Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
59	MEDICAL SUPPLIES	CMS Code		Unit	
60	catheter, balloon, rectal pressure	SD017		1	
61	transducer dome (pressure)	SD125		1	
62	tubing, pressure	SD131		1	
63	drape-towel, sterile 18in x 26in	SB019		1	
64	underpad 2ft x 3ft (Chux)	SB044		1	
65	stop cock, 4-way	SC050		1	
66	syringe 10-12ml	SC051		1	
67	pack, minimum multi-specialty visit	SA048		1	
68	pack, urology cystoscopy visit	SA058		1	
69	patient education booklet	SK062			
70	tape, surgical paper 1in (Micropore)	SG079		12	
71	Equipment	CMS Code			
72	table, instrument, mobile	EF027			
73	table, power	EF031			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Pelvic Interstitial Brachytherapy Needle or Catheter Placement

In February 2007 the CPT Editorial Panel created a new CPT code to describe surgical placement of brachytherapy needles or catheters in the pelvis (other than for prostate).

The RUC reviewed the survey results of 57 radiation oncologists considering the physician time, effort, intensity and complexity of the new procedure 55920 *Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application*. The RUC compared the new service to code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 8.31), and believed that new code 55920 was similar in physician work, time, and intensity. In addition, the RUC believed that the pre-service physician time should be reduced by a total of 25 minutes to reflect the typical patient evaluation and positioning time. The RUC also reviewed a building block methodology using the specialty's reference service 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (work RVU = 13.31) (090 day global). As an additional approach, the RUC took the reference service code value of 13.31 RVUs and extracted the physician work of code 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23), and its three level 3 evaluation and management office visit (99213) RVUs (2.76 RVUs), resulting in a similar value of 8.32 RVUs. The RUC also determined that for this service the typical patient service would require a pre-service evaluation time of 30 minutes, positioning of 10 minutes, 15 minutes for scrub, dress, and wait, an intra-service time of 90 minutes, and an immediate post service time of 30 minutes, for code 55920.

The RUC recommends a physician work relative value of 8.31 for CPT code 55920.

Practice Expense

The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●55920	LL1	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application (For placement of needles or catheters into prostate, use 55875) (For insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy, report code 57155) (For insertion of Heyman capsules for clinical brachytherapy, use 58346)	000	8.31
Surgery **Female Genital System** **Vagina Introduction**				
57155		Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy (For placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for interstitial radioelement application, use code 55920)	090	6.79 (No Change)
Surgery **Female Genital System** **Corpus Uteri Introduction**				
58346		Insertion of Heyman capsules for clinical brachytherapy (For placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for interstitial radioelement application, use code 55920)	090	7.48 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:55920 Tracking Number LL1 Specialty Society Recommended RVU: **10.50**
Global Period: 000 RUC Recommended RVU: **8.31**

CPT Descriptor: Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year old woman presents with pelvic pain and vaginal bleeding. Pelvic exam reveals the cervix is replaced by tumor and bimanual examination reveals that the tumor extends to one pelvic sidewall. A biopsy shows squamous cell carcinoma of the cervix. The staging work-up is negative for metastasis. External beam irradiation with concomitant chemotherapy is administered and the patient is scheduled for interstitial brachytherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 35%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review initial exams, radiation and chemotherapy records including related toxicities and labs. Obtain consent and educate patient and family about procedure. Review preoperative imaging and plan catheter placement. Discuss implant volume, placement and spacing with the brachytherapy team. Select, assemble, and if necessary order requisite brachytherapy catheters and supplies. Dress, scrub, and wait.

Description of Intra-Service Work: After anesthesia, the patient is placed in the lithotomy position and sequential compression devices are fitted. Perineum and pelvis are examined for effects of chemotherapy and radiation on normal tissue. A speculum examination and bimanual recto-vaginal examination is performed to determine the extent and distribution of disease.

The perineum and vagina are prepared and draped. A radio-opaque bladder catheter with a surgical steel ring to mark the urethral meatus is inserted into the bladder. Counter-traction sutures are placed in the cervix or adjacent vaginal wall. A template device and vaginal cylinder are selected and prepared for orienting the brachytherapy needles or catheters through the vagina directly into the cervical cancer, through the perineum, directly into the parivaginal tissue and perimetria and into the pelvic side wall. Template modification is performed as needed to fit the perineum for patient comfort. The number of brachytherapy catheters selected and the depth of insertion are adjusted according to the extent and distribution of the disease, but typically 32 flexiguide needles, with a length of 25cm, are inserted during this procedure.

The cervical os is identified and uterus is sounded if possible. A guide probe and wire are inserted into the uterus to orient the direction and depth of brachytherapy catheter placement. The vaginal cylinder is inserted over the probe and the template is fitted over the cylinder to create a probe, cylinder, and template assembly. The template and cylinder are locked together, and the counter-traction sutures are threaded through the template with a pull wire and attached to hemostats.The template guide ports are selected so that the disease is fully encompassed by the implant catheters in the anterior-posterior and transverse planes.

The brachytherapy needle or catheter insertion begins around the vaginal cylinder. Catheters are advanced along the length of the vaginal cylinder until the cervical lesion is encounters. Counter-traction is applied as the brachytherapy needles/catheters are then inserted to a depth consistent with the known extent of the disease (usually about 4-6cm). Subsequent needles/catheters are inserted directly through the perineum using counter-traction. Beginning anterior and working posterior they are advanced parallel to the initial guides into the paravaginal and parametrial targets to a depth consistent with the guides. A double-gloved digital rectal palpation of the pelvic structures is utilized to guide the

posterior aspect of the applicator placement. Typically 32 catheters are utilized to encompass the disease involving parametria with extension to the pelvic sidewall. The template is secured to the perineum in by wrapping and tying the counter-traction sutures around the base of the template. Four additional bolster sutures are placed in the perineum to hold template firmly in place and to protect normal tissue from pressure injury. A 22-gauge 30cc Foley catheter is inserted into the rectum for delivery of rectal contrast. Catheter relationships, final adjustments, and total counts are performed to complete the procedure.

Description of Post-Service Work: The physician diagrams the implant in the patient's medical record. Dictates the procedure report and writes orders. The patient is examined with carful attention paid to the airway and catheter wounds. The physician communicates with physics/dosimetry staff regarding subsequent radioelement application. Answers patient and family questions. Coordinates post operative imaging. Answers nursing and other staff questions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Najeeb Mohideen, M.D., Michael Kuettel, M.D., MBA, PhD, David Beyer, M.D.					
Specialty(s):	Radiation Oncology					
CPT Code:	55920					
Sample Size:	600	**Resp N:** 57	**Response:** 9.5 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	2.00	**5.00**	8.00	100.00
Survey RVW:		6.50	12.75	**14.00**	16.00	45.00
Pre-Service Evaluation Time:				**50.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	60.00	**90.00**	90.00	200.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 55920	
	Specialty Recommended
Physician Work RVU:	10.50
Pre-Service Evaluation Time:	30.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	15.0
Intra-Service Time:	90.00
Immediate Post Service-Time:	30.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55875	090	13.31	RUC Time

CPT Descriptor Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
43269	000	15,294	8.20	RUC Time

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 66.6 %

TIME ESTIMATES (Median)	CPT Code: 55920	Key Reference CPT Code: 55875	Source of Time RUC Time
Median Pre-Service Time	55.00	50.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**175.00**	**249.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.31	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	3.84
Urgency of medical decision making	4.09	3.37
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.78	4.34
Physical effort required	4.49	3.84
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.78	4.03
Outcome depends on the skill and judgment of physician	4.80	4.37

Estimated risk of malpractice suit with poor outcome	4.45	3.97

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.25	3.84
Intra-Service intensity/complexity	4.65	4.13
Post-Service intensity/complexity	4.02	3.71

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Almost 60 physician work surveys were completed by our membership for this new CPT code. The data from those surveys were collected, reviewed and analyzed by a consensus panel, consisting of members of ASTRO's Health Policy and Code Development and Valuation Committee, as well as brachytherapy experts in the field of radiation oncology. The group reviewed the survey data and recommends a work RVU of 10.5 for this new procedure code, a value less then the 25th percentile.

The panel reviewed the data for this new CPT code, along with the reference service code and the two other new CPT codes for similar procedures, being presented at this RUC meeting. And although the panel agreed with the survey respondents that the RVU should be established at a rate higher then the panel is recommending, the survey response times, along with the surveyed RVU recommendations, create an IWPUT that would create a rank order anomaly. The panel has reviewed the family of these codes and feels that following is an appropriate rank order:

Surveyed Code:	41019	IWPUT 0.09723
Reference Service Code:	55876	IWPUT 0.09482
Surveyed Code:*(this survey)*	**55920**	**IWPUT 0.09167**
Surveyed Code:	20555	IWPUT 0.083

The panel feels the procedure described by this new CPT code is a little less intense then the work described in the reference service code.

The panel recommends the median survey times for this procedure (*one exception) and recommends they be entered into the RUC database: 20 minutes of pre-service evaluation time, 15 minutes for pre-service positioning, 15 minutes for pre-service scrub, dress and wait , 90 minutes of intra-service time, and 30 minutes of immediate post-service time. The society recommends 30 minutes day preceding procedure be entered into the RUC database, instead of the median of 35 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
   CPT Code: 77014; Computed tomography guidance for placement of radiation therapy fields
   Global Period: XXX
   Work RVUs: TC-Only
   Total Time: 17 minutes

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
-57155; Insertion of uterine tandem and/or ovoids for clinical brachytherapy
58346; Insertion of Heyman capsules for clinical brachytherapy
58999; unlisted procedure, female genital system (nonobstetrical)
53899; unlisted procedure, urinary system
55899; unlisted procedure, male genital system
45999; unlisted procedure, rectum
46999; unlisted procedure, anus

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology How often? Sometimes

Specialty Gynecologic Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 800
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. This type of procedure will most likely be performed by a radiation oncologist, but occassionally could be performed by a gynecologic oncologist and therefore we have indicated that below.

Specialty Radiation Oncology Frequency 720 Percentage 90.00 %

Specialty Gynecologic Oncology Frequency 80 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 540
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the total number of times this service us provided annually, the recipient is an elderly patient.

Specialty Radiation Oncology Frequency 486 Percentage 90.00 %

Specialty Gynecologic Oncology Frequency 54 Percentage 10.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 52345

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Non-Facility Direct Inputs

CPT Long Descriptor: Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.

Sample Size: N/A **Response Rate: (%):** N/A **Global Period:** 000

EXPERT PANEL USED TO DEVELOP RECOMMENDATION

Geographic Practice Setting %: **All geographic practice settings represented.**

Type of Practice %: **All practice types represented.**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Therapeutic Radiology and Oncology (ASTRO) prepared these practice expense reccommendations using a consensus panel of physicians comprised of members from ASTRO's Health Policy Committee, Code Development and Valuation Committee (CDVC), as well as those physicians that perform brachytherapy implant placement procedures. The consensus panel included physician representatives from states in various regions of the United States and all demographic areas.

The consensus panel members held several conference calls to evaluate the non-physician clinical labor times, medical supplies, and equipment, based upon the panel members' experience with the procedure under consideration. Preliminary recommendations for direct inputs were drafted and distributed for discussion by the panel during these conference calls, which led to the final formulated practice expense recommendations for CPT® Code 55920; *Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.* Although ASTRO was also scheduled to make non-facility practice expense recommendations for this procedure, we felt that it was appropriate to only make recommendations for the facility setting at this time.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Schedule procedure, confirm all applicable supplies and devices are available.

Retrieve and compile all relevant clinical information, including all preoperative imaging studies, and patient's medical record for review by the physician. Verify orders, and confirm procedure protocol with physician.

Contact patient on the day before the procedure to provide educational information regarding the procedure and provide them with any additional information they may request. Obtain informed consent and confirm adherence to pre procedure protocol.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Initiate phone calls for physician and call in prescriptions as applicable.

****Please see corresponding PERC spreadsheet for additional details.**

	A	B	C	D	E
2				55920	
3	April 2007 AMA/Specialty Society RVS Update Society Recommendation			*Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.*	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD			000	000
6	TOTAL CLINICAL LABOR TIME			0.0	33.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	30.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0
10	PRE-SERVICE				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		10
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		7
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3
17	Other Clinical Activity (please specify)				
18	**End:When patient enters office/facility for surgery/procedure**				
19	SERVICE PERIOD				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning	L037D	RN/LPN/MTA		
24	Obtain vital signs	L037D	RN/LPN/MTA		
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA		
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA		
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure	L037D	RN/LPN/MTA		
32	**Post-Service**				
33	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA		
34	Clean room/equipment by physician staff	L037D	RN/LPN/MTA		
35	Clean Scope	L037D	RN/LPN/MTA		
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA		
40	Discharge day management 99238 --12 minutes 99239 --15 minutes				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				
43	POST-SERVICE Period				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3
46	*Office visits:*				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54	*Total Office Visit Time*			0	0
55	Other Activity (please specify)				
56	**End: with last office visit before end of global period**				
57	MEDICAL SUPPLIES	CMS Code	Unit		
58	pack, drapes, cystoscopy	SA045	pack		
59	pack, minimum multi-specialty visit	SA048	pack		
60	syringe 20ml	SC053	item		
61	needle, spine, Sprotte	SC042	item		
62	cover-condom, transducer or ultrasound probe	SB005	item		
63	kit, gold markers, fiducial, 3 per kit	N/A	kit		
64	lidocaine 1%-2% inj (Xylocaine)	SH047	ml		
65	Equipment	CMS Code			
66	table, power	EF031			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Percutaneous Renal Tumor Cryotherapy

In November 2006, the CPT Editorial Panel converted category III code 0135T *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* to a category I code as it determined the service was now performed across the country in multiple locations and the device had FDA approval.

The RUC reviewed two services that were similar in physician time and intensity across specialties to arrive at value for new code 50593. The RUC reviewed code 50592 *Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency* (work RVU = 6.77, 010 day global) and believed 50593 required more physician time due to the complexity of the procedure, but had similar intra-work intensity. The RUC and the specialty determined that the survey respondents overestimated the pre-service time and that pre-service positioning and pre-service scrub, dress, and wait time each should be reduced to 10 minutes to be consistent with code 50592. The RUC recommends 45 minutes of pre-service evaluation time, less than the survey but significantly more than for 50592 due to the complexity of the typical patient for 50593.

Using code 50592 as an anchor for a building block methodology, the Committee developed a work relative value of 9.08 for 50593. The RUC concurred that the intensity of code 50592 was quite similar to this new service, however 50592 requires one probe and new service 50593 requires four 12 gauge cryoablation probes that results in an additional 30 minutes of intra-service physician time. The intensity of 50592 was utilized, as well as the typical patient pre, intra, and post service physician time components were used in the following building block methodology, that results in the RUC's recommended physician work RVU of 9.08.

The RUC also reviewed code 31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy* (work RVU = 9.23, 010 day global), as a cross specialty comparison and agreed that while its intra-work was less intense, its total work was similar to 50593.

The RUC recommends a relative work value of 9.08 for code 50593.

New Technology: The RUC recommends code 50593 to be added to the new technology list.

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Physician Time Components	Intensity	Time	Associated RVUs
Pre-Service Eval	0.0224	45	1.01
Pre-Service Position	0.0224	10	0.22
Pre-Service Scrub, dress, wait	0.0081	10	0.08
Immediate Post	0.0224	20	0.45
Intra-service IWPUT of code 50592	0.0640	90	5.76
	Post Operative Visit		
	99238	0.5	0.64
	99213	1	0.92
		Work Value	**9.08**

Practice Expense

The RUC reviewed the specialty recommended direct practice expense inputs for the non-facility and facility settings and made minor modifications to the clinical labor time to reflect the typical patient scenario. **The RUC recommends the attached direct practice expense inputs for code 50593.**

1304

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
⊙●50593	MM1	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy (50593 is a unilateral procedure. For bilateral procedure, report 50593 with modifier 50) (For imaging guidance and monitoring, see codes 76940, 77013, 77022)	010	9.08
Category III				
D 0135T		~~Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy~~ (0135T has been deleted. To report, use 50593)		N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:50593 Tracking Number MM1 Specialty Society Recommended RVU: **13.00**
Global Period: 010 RUC Recommended RVU: **9.08**

CPT Descriptor: Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
(505XX is a unilateral procedure. For bilateral procedure, report 505XX with modifier 50)
(For imaging guidance and monitoring, see codes 76940, 77013, 77022)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old man with poor cardiac function and history of previous open-heart surgery has a 3.0 cm enhancing solid renal mass that was incidentally found as result of a CT scan performed due to patient's complaint of abdominal pain. The patient's comorbidities rule out open total or partial nephrectomy as too risky. The patient is referred for percutaneous renal tumor ablation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 64%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: The physician,
The physician:
-Obtains and reviews pertinent imaging studies and lab results
-Discusses procedure and alternatives with patient and family; answers questions and informed consent is reviewed with patient and family
-Orders blood work including a coagulation profile
-Instructs patient and/or relative to pre-procedural diet and alterations in medication
-Calls patient to ensure compliance with dietary and medication instructions and to answer any remaining questions
-Estimates the range of devices that may be required and ensures all are available for use
-Ensures all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
-Supervises selection of all equipment, incuding catheters, wires, sheaths, contrast material and other devices
-Re-reviews applicable, available prior films

Description of Intra-Service Work: The physician,
-Confirms clinical status has not changed
-Supervises the start of an IV
-Oversees the equiping of the room, the positioning of the patient, and the dispersement skin temperature sensors
-Obtains and interprets initial localization image (included in 77013, 77022 or 76940 -- separately reportable) for selection of the entry site for initial probe placement
-Supervises nurse's administration of a dose (or doses) of i.v. conscious sedation which typically is 50ugs fentanyl and 1mg midazolam
-Makes small incisions to facilitate placement of multiple probes (4-6 probes). This is done to assure complete tumor necrosis and satisfactory margins
-Introduces 12 gauge, cryoablation probes into the center of the lesion under imaging guidance (imaging included in 77013, 77022 or 76940) to avoid organs and major blood vessels
-Confirms location of probe tips using imaging guidance (imaging included in 77013, 77022 or 76940)
-Activates cryoablation unit until satisfactory creation of cryoablation sphere (iceball) is achieved. Typically two freeze cycles required
-Monitors and assesses tumor necrosis to confirm the completion of treatment
-Withdraws the probes, after satisfactory necrosis
-Cleans incision sites and applies sterile adhesive dressings

Description of Post-Service Work: The physician,
-Follows patient to recovery
-Writes orders for additional pain medication
-Discusses procedure and the planned subsequent course of therapy with the patient and the patient's family
-Checks on patient in recovery for complications and comfort
-Discharges patient with post-procedure instructions
-Dictates, review, and sign report of the procedure
-Discusses outcome with primary care physician
-Follows patient with telephone calls
-Sees patient in office for follow-up

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Robert L. Vogelzang, MD, Sean Tutton, MD, Geraldine McGinty, MD, Jonathan W. Berlin, MD, James Giblin, MD, William (Bruce) Shingleton, MD					
Specialty(s):	Interventional Radiology, Radiology, and Urology					
CPT Code:	50593					
Sample Size: 427	**Resp N:** 48	**Response:** 11.2 %				
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	6.00	**12.00**	21.00	100.00
Survey RVW:		6.77	13.00	**16.50**	21.00	30.00
Pre-Service Evaluation Time:				**75.0**		
Pre-Service Positioning Time:				**20.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	90.00	**90.00**	120.00	180.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**40.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 50593		
		Specialty Recommended
Physician Work RVU:		13.00
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	23.0	99211x 0.0 12x 0.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
50542	090	21.18	RUC Time

CPT Descriptor Laparoscopy, surgical; ablation of renal mass lesion(s)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
38571	010	1,465	14.70	RUC Time

CPT Descriptor 1 Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49320	010	10,774	5.09	RUC Time

CPT Descriptor 2 Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source

47382 010 15.19 **RUC Time**

CPT Descriptor Ablation, one or more liver tumor(s), percutaneous, radiofrequency

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 29.1 %

TIME ESTIMATES (Median)	CPT Code: 50593	Key Reference CPT Code: 50542	Source of Time RUC Time
Median Pre-Service Time	65.00	75.00	
Median Intra-Service Time	90.00	180.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	23.0	86.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**217.00**	**449.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.29	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	4.21
Urgency of medical decision making	3.50	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.57	3.86
Physical effort required	4.71	4.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.21	4.14
Outcome depends on the skill and judgment of physician	4.64	4.31

Estimated risk of malpractice suit with poor outcome	4.29	4.07

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	4.07
Intra-Service intensity/complexity	4.43	4.46
Post-Service intensity/complexity	3.07	3.29

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society RUC workgroup was convened to review survey results. The survey median recommended RVU was believed to be excessively high compared to other ablative therapies. The survey 25th percentile recommended RVU is believed to be relative to other clinically similar ablative therapies. IWPUT was calculated, as follows:

Pre-service RVU = 2.2495 = 0.0224*(75 +20) + (0.0081*15)

Post-service RVU = 3.296 = (0.0224*20) + 0.76 + 1.28 + 0.92

25th PERCENTILE RECOMMENDED RVU = 13.00

Intra-service RVU = 7.3425

IWPUT = 0.08158 = 7.3425 /90

Per survey, typical E&M Visits:

In patient	99231 – 1	Physician Work RVUs	0.76
Discharge Day Mgmt	99238 – 1	Physician Work RVUs	1.28
Office Visit	99213 – 1	Physician Work RVUs	0.92

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) Depending on the patients clinical circumstances and operator preference, different imaging modalities may be used to guide and monitor the ablation procedure.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.		50593 plus	76940 or	77013 or	77022	Total
4.	Global Period	010	XXX	XXX	XXX	
5.	RVW	13	2.00	3.99	4.24	15.00 to 17.24
6.	Pre-time (minutes)	110	20	20	20	130 minutes
7.	Intra-time (minutes)	90	120	120	165	210 to 255 minutes
8.	Post-time (minutes)	15	15	15	15	30 minutes
9.	Total time (minutes)	215	155	155	200	370 to 415 minutes

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT codes 49999 (Unlisted procedure, abdomen, peritoneum, and omentum) or code 53899 (Unlisted uninary system) plus 77013, 77022 or 76940 depending on imaging modality used for guidance and ablation monitoring.

The Medicare 2005 frequencies for code 49999 and 53899 were 1570 and 3179, respectively. We are unable to determine the number of renal tumor(s) cryoablation procedures that may be included in these figures. For renal tumors, surgery is the primary therapy. Ablation would be reserved for patients who are poor candidates for surgery due to multiple comorbidities or who oppose surgery. Therefore, the number of renal tumo(s) cryoablations being performed today should be relatively small.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology & Interventional Radiology How often? Rarely

Specialty Urology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2341
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Assumes that approximately 50% of the unlisted procedures reported using unlisted codes 49999 and 53899 in 2005 were renal cyotherapy procedures. For code 49999, 14.14% of the services reported were reported by diagnostic and interventional radiology represent, 71.08% by general surgery and 1.97% by urology. For code 53899, 35.51% of the services reported were reported by diagnostic and interventional radiology, 0.5% by general surgery and 61.19% by urology.Medicare patients are believed to be the preponderance of those receiving these service. A reasonable estimate of non-Medicare patients receiveing these services is believed to be about 5% above that of Medicare.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 709 Percentage 28.83 %

Specialty Urology Frequency 1037 Percentage 44.29 %

Specialty General Surgery Frequency 594 Percentage 25.37 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2229 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumes that approximately 50% of the unlisted procedures reported using unlisted codes 49999 and 53899 in 2005 were renal cyotherapy procedures. For code 49999, 14.14% of the services reported were reported by diagnostic and interventional radiology represent, 71.08% by general surgery and 1.97% by urology. For code 53899, 35.51% of the services reported were reported by diagnostic and interventional radiology, 0.5% by general surgery and 61.19% by urology.

Specialty Diagnostic Radiology & Interventional Radiology Frequency 675 Percentage 30.28 %

Specialty Urology Frequency 988 Percentage 44.32 %

Specialty General Surgery Frequency 566 Percentage 25.39 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 50592 is believed to be a better PLI crosswalk; similar to 505XX, 50592 represents a percutenous procedure for the ablation of renal tumor(s) with imaging separately reportable.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Non Facility Direct Inputs

CPT Long Descriptor:

50593- Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

(50593 is a unilateral procedure. For bilateral procedure, report 50593 with modifier 50)

(For imaging guidance and monitoring, see codes 76940, 77013, 77022)

Sample Size N/A Response Rate: (%): N/A Global Period: 010

Expert Panel Used to Develop Recommendation

Geographic Practice Setting %: **All geographical practice settings represented**

Type of Practice %: **All practice types represented**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Members known to provide the service for which practice expense inputs are being developed in a non-facility setting were contacted to provide inputs. Industry was contacted as applicable regarding current pricing for new devices and/or existing devices for which there has been a known price increase. Like inputs were identified. Society RUC workgroup members evaluated unique inputs for inclusion as appropriate within the context of established standard inputs for like and/or related procedures/services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Schedule procedure and confirm applicable supplies and devices are in inventory**
- **Retrieve and compile all relevant clinical information for patient record for review by physician including incorporation of all relevant clinical information, verify orders, confirm procedure protocol with physician**
- **Contact patient the day before procedure to confirm adherence to pre-procedure protocol.**

Intra-Service Clinical Labor Activities:

- **Review and prepare chart to insure completeness in preparation for physician**

review

- **Greet patient and provide gowning**
- **Reaffirm informed consent and obtain vital signs**
- **Prepare room including locating and preparation of all applicable devices and supplies**
- **Prepare patient for procedure and set up IV**
- **Assist physician in performing procedure**
- **Assist physician in monitoring moderate (conscious) sedation**

Post-Service Clinical Labor Activities:

- **Monitor patient post procedurally, checking vital signs every 20 minutes**
- **Clean room in accordance with OSHA regulations**
- **Check wound and review post procedure instructions with patient**
- **Review x-ray and lab results for physician review and interpretation with incorporation in patients medical record**
- **Initiate phone calls for physician and call in prescriptions as applicable**
- **Support physician in providing follow up E&M services**

Please see corresponding PERC spreadsheet for additional detail.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

50593- Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

(50593 is a unilateral procedure. For bilateral procedure, report 50593 with modifier 50)

(For imaging guidance and monitoring, see codes 76940, 77013, 77022)

Sample Size N/A Response Rate: (%): N/A Global Period: 010

Expert Panel Used to Develop Recommendation

Geographic Practice Setting %: **All geographical practice settings represented**

Type of Practice %: **All practice types represented**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Members known to provide the service for which practice expense inputs are being developed in an in-facility setting were contacted to provide inputs. Like inputs were identified. Society RUC workgroup members evaluated unique inputs for inclusion as appropriate within the context of established standard inputs for like and/or related procedures/services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Schedule procedure and confirm applicable supplies and devices are in inventory**
- **Retrieve and compile all relevant clinical information for patient record for review by physician including incorporation of all relevant clinical information, verify orders, confirm procedure protocol with physician**
- **Contact patient the day before procedure to confirm adherence to pre-procedure protocol**

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- **Initiate phone calls for physician and call in prescriptions as applicable**
- **Support physician in providing follow-up E&M services**

	A	B	C	D	E
1				50593	
2	April 2007 AMA/Specialty Society Update Committee Recommendation			Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy (505XX is a unilateral procedure.	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD: 10			010	010
5	TOTAL CLINICAL LABOR TIME			285.0	66.0
6	RN/LPN/MTA	L037D	RN/LPN/MTA	71.0	66.0
7	RN	L051A	RN	122.0	
8	RT	L041B	RT	92.0	
9	TOTAL PRE-SERV CLINICAL LABOR TIME			12.0	30.0
10	RN/LPN/MTA	L037D	RN/LPN/MTA	12.0	30.0
11					
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			237.0	6.0
13	RN/LPN/MTA	L037D	RN/LPN/MTA	23.0	0.0
14	RN	L051A	RN	122.0	
15	RT	L041B	RT	92.0	
16	TOTAL POST-SERV CLINICAL LABOR TIME			36.0	36.0
17	RN/LPN/MTA	L037D	RN/LPN/MTA	36.0	36.0
18					
19	[illegible]				
20	**Start: Following visit when decision for surgery or procedure made**				
21	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5
22	Coordinate pre-surgery services	L037D	RN/LPN/MTA	7	17
23	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
24	Provide pre-service education/obtain consent				
25	Follow-up phone calls & prescriptions				
26	Other Clinical Activity (please specify):				
27	**End:When patient enters office/facility for surgery/procedure**				
28	[illegible]				
29	**Start: When patient enters office/facility for surgery/procedure**				
30	**Pre-service services**				
31	Review charts	L037D	RN/LPN/MTA	2	
32	Greet patient and provide gowning	L037D	RN/LPN/MTA	3	
33	Obtain vital signs	L037D	RN/LPN/MTA	5	
34	Provide pre-service education/obtain consent				
35	Prepare room, equipment, supplies	L041A	RT	2	
36	Setup scope (non facility setting only)				
37	Prepare and position patient/ monitor patient/ set up IV	L051A	RN/LPN/MTA	2	
38	Sedate/apply anesthesia	L051A	RN	2	
39	**Intra-service**				
40	Assist physician in performing procedure	L041B	RT	90	
41	Conscious Sedaton monitoring dedicated personnel	L051A	RN	90	
42	**Post-Service**				
43	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	30	
44	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3	
45	Clean Scope				
46	Clean Surgical Instrument Package				
47	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	5	
48	Review/read X-ray, lab, and pathology reports				
49	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3	
50	Discharge day management 99238 –12 minutes 99239 –15 minutes	L037D	RN/LPN/MTA		6
51	Other Clinical Activity (please specify)				
52	**End: Patient leaves office**				
53	[illegible]				
54	**Start: Patient leaves office/facility**				
55	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	0
56	*Office visits:*				
57	*List Number and Level of Office Visits*				
58	99211 16 minutes		16		
59	99212 27 minutes (		27		
60	99213 36 minutes		36	1	1
61	99214 53 minutes		53		
62	99215 63 minutes		63		
63	Other				
64					
65	*Total Office Visit Time*			36	36
66	Other Activity (please specify)				
67	**End: with last office visit before end of global period**				

	A	B	C	D	E
1				50593	
2	April 2007 AMA/Specialty Society Update Committee Recommendation			Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy (505XX is a unilateral procedure.	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
68	[redacted]				
69	pack, minimum multi-specialty visit	SA048	pack	2	1
70	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1	
71	Applicator, spong tip	SG009	item	1	
72	tape, surgical paper 1in (Micropore)	SG079	inch	12	
73	gauze, sterile 4in x 4in	SG055	item	3	
74	povidone solution (Betadine)	SJ041	ml	60	
75	tray, shave prep	SA067	tray	1	
76	lidocaine 1-2% inj (Xylocaine)	SH047	ml	10	
77	mask, surgical, with face shield	SB034	item	3	
78	drape, sterile, fenestrated 16in x 29in	SB011	item	1	
79	gloves, sterile	SB024	pair	2	
80	drape-towel, sterile 18inx26in	SB019	item	4	
81	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2	
82	underpad 2ftx3ft (Chux)	SB044	item	1	
83	shoe covers, surgical	SB039	pair	2	
84	cup-container, sterile, graduated, 1000ml	SL038	item	1	
85	blade, surgical (Bard-Parker)	SF007	item	1	
86	drape, sterile, femoral	SB009	item	1	
87	gown, surgical, sterile	SB028	item	2	
88	needle, 18-27g	SC029	item	1	
89	cap, surgical	SB002	item	2	
90	dressing 3 X 4 wound care telfa	SG035	item	2	
91	tape, surgical paper 1in (Micropore)	SG079	item	6	
92	Tegaderm dressing	SG037	item	1	
93	biohazard bag	SM004	item	2	
94	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1	
95	pack, conscious sedation	SA044	pack	1	
96	cryoablation probe	NEW	item	4	
97	Argon gas, Helium gas		Item		
98					
99					
100	[redacted]				
101	room, CT	EL007		1	
102	Cryosurgery system, tumor ablation	NEW		1	
103	infusion pump	EQ032		1	
104	stretcher	EF018		1	
105	pulse oximeter w-printer	EQ211		1	
106	light, exam	EQ168		1	1
107	table, exam	EF023		1	1
108	ECG, 3-channel (with Sp02, NIBR	EQ011		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Prostate Laser Enucleation

The CPT Editorial Panel created a new CPT code to provide greater specificity to other prostate procedures currently in CPT. Current CPT code 52648 *Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (Work RVU = 12.00) describes the vaporization of prostate tissue with subsequent prostatic fossa cavitation. This is accomplished by contacting a bare tip laser fiber (under high energy) to the prostate surface and painting the tissue. Tissue underneath the fiber immediately vaporizes. This new code describes the use of the laser fiber to undermine and dissect away large pieces of prostate tissue which migrate into the bladder and are subsequently extracted at the end of the procedure.

1319

The RUC reviewed the specialty society's survey results for new code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* and discussed the typical patient regarding this new service. The survey results were tight from the 33 respondents who had performed the service a median of 20 times. The service is only safely performed in the facility setting, and typically is for patients who have an enlarged prostate that results in obstructive voiding symptoms. In relation to this new code the RUC also reviewed the specialty's key reference service code 55831 *Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal* (Work RVU = 17.06), and agreed the physician work, time, and complexity was similar to the new service. The RUC concurred that the survey results median work relative value of 17.16 was appropriate for this new procedure. **The RUC recommends a relative work value of 17.16 for new code 52649.**

Practice Expense

The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time reflecting the PERC's 090 day global standard direct practice expense inputs.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
52601		Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	090	15.13 (No Change)
52647	NN1	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	090	11.15 (No Change)
52648	NN2	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	090	12.00 (No Change)
●52649	NN3	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) (Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)	090	17.16

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:52649 Tracking Number 2941PA Specialty Society Recommended RVU: **17.16**
Global Period: 090 RUC Recommended RVU: **17.16**

CPT Descriptor: Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) (Do not report 5264X in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year-old male with a long history of obstructive voiding symptoms experiences nocturia 5 to 6 times and a poor stream. His AUA symptom score is 32. On rectal examination, he is noted to have a markedly enlarged prostate which is smooth and symmetrical. A PSA is 3.9 and a transrectal ultrasound reveals a 262 gm prostate. After discussion of the treatment options, he elects holmium laser Enucleation as a definitive treatment for his BPH.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 6%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service Work- Day before surgery: Review pre-op lab results. Review medical record. Write pre-op orders (to be faxed to hospital). Pre-service work- Day of surgery: Change into scrub clothes. Review surgical procedure, post-op recovery in and out of hospital with patient and family. Answer patient and family questions, be sure informed consent is in record. Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems). Position patient on endoscopic table. Verify that all necessary instruments are available. Take "time out" for patient identification. Wait for anesthesiologist to give the anesthetic (general or spinal).

Description of Intra-Service Work: Under appropriate anesthesia, the patient is placed in the lithotomy position and prepped and draped. Cystoscopy (of the bladder prior to the enucleation to make sure there are no tumors or masses in the bladder. Urethral calibration and dilatation (passing sounds in the urethra to make sure it can accommodate the scope. Possible meatotomy if there is narrowing at the meatus (preventing the passage of the scope). A 28 French continuous flow resectoscope sheath is passed into the bladder. The laser bridge, a 7 French laser stabilizing catheter and a 550 micron end firing holmium laser fiber are utilized. The holmium laser is set at 100 watts for dissection. Inspection of the prostatic urethra reveals a very large prostate with tri-lobar enlargement. Enucleation is begun by making an incision at the 5 o'clock location between the median lobe and left lateral lobe. Dissection is carried down to the capsule and from the bladder neck to the veru montanum. Once the groove has been cut, it is undermined on each side, thereby enucleating each lateral lobe of the prostate, as well as the median lobe. The anterior commissure is then divided at the 12 o'clock location and the anterior lobe dissected free. Hemostasis is achieved by defocusing the laser fiber. The large pieces of prostate tissue are then morcellated and extracted with an Ellik evacuator. Reinspection of the bladder shows no residual chips and excellent prostatic hemostasis. A 22 French 3-way catheter is the placed and the patient is taken to the recovery room.

Description of Post-Service Work: Post-op Same day work through discharge from recovery. Wait for anesthesiologist to awaken patient. Transfer patient off of operating table. Attach irrigation to 3-way Foley catheter. Hand irrigate Foley catheter in operating room before transfer to recovery room. Go with patient and anesthesiologist to recovery room. Assist in transfer of patient to recovery area bed. Review recovery area care and medications with staff . Meet with patient's family and discuss the procedure, expected outcome, planned post-operative care in hospital and out of hospital. Discuss procedure with patient as necessary in recovery area when awake. Conduct post-op pain

assessment. Write post-operative orders. Dictate operative report. Call referring physician regarding outcome of procedure and any unusual aspects of post-operative care (cardiac disease, diabetic management. Post-op Same day work after discharge from recovery - Examine patient, check bladder and patient progress. Conduct post-op pain assessment. Hand irrigate clots out of catheter. Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner). Answer patient and family questions. Answer nursing and other staff questions. Write any further necessary orders. Write note in progress note section of medical record. Post-op Other Hospital Work - Beginning on post op-day 1, until discharge day - Examine and talk to patient. Conduct post-op pain assessment. Check lab values. Check catheter and irrigation, and irrigate as necessary. Discuss patient progress with patient and family. Review all patient hospital medical record notes. Discuss post operative care of catheter at home with patient and family. Answer nursing and other staff questions. Answer patient and family questions. Write any further necessary orders in medical record. Write note in progress note section of medical record Discharge day work: Examine patient and talk with patient and family. Conduct post-op pain assessment. Check catheter and patient progress. Review all patient hospital medical records. Answer patient and family questions. Write orders for post-discharge care. Write prescriptions for post-op medications. Discuss post-op care of catheter with patient and family. Dictate hospital discharge summary Post-op Office work- After discharge from hospital: Examine patient, check vital signs. Conduct post-op pain assessment oRemove Foley catheter in office . Talk with patient and family. Patient to return to office next day to see if voiding satisfactorily. Reinsert Foley catheter if unable to void. In subsequent visits, examine patient, assess voiding pattern, check residual urine volume, check urinalysis and urine culture. Write necessary prescriptions. Schedule next office visit. Dictate patient progress notes for office medical record o Dictate letter to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	James G. Giblin, M.D.; James E. Lingeman, M.D.					
Specialty(s):	Urology					
CPT Code:	52649					
Sample Size:	52	**Resp N:** 33	**Response:** 63.4 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		2.00	6.00	**20.00**	40.00	150.00
Survey RVW:		15.00	16.00	**17.16**	23.25	30.00
Pre-Service Evaluation Time:				**70.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		75.00	120.00	**180.00**	185.00	240.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**20.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 52649		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		0.00
Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
55831	090	17.06	Harvard Time

CPT Descriptor Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
50220	090	2,285	18.53	RUC Time

CPT Descriptor 1 Nephrectomy, including partial ureterectomy, any open approach including rib resection;

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58660	090	2,276	11.54	RUC Time

CPT Descriptor 2 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 60.6 %

TIME ESTIMATES (Median)	CPT Code: 52649	Key Reference CPT Code: 55831	Source of Time Harvard Time
Median Pre-Service Time	95.00	56.00	
Median Intra-Service Time	180.00	114.00	
Median Immediate Post-service Time	30.00	27.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	130.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	57.50	
Prolonged Services Time	0.0	0.00	
Median Total Time	**425.00**	**422.50**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.41
Urgency of medical decision making	3.39	3.12
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.91	3.52
Physical effort required	4.39	3.61
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.12	3.73
Outcome depends on the skill and judgment of physician	4.78	3.73

Estimated risk of malpractice suit with poor outcome	4.00	3.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.55	3.30
Intra-Service intensity/complexity	4.67	3.73
Post-Service intensity/complexity	3.42	3.36

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52601

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 450
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Urology	Frequency 450	Percentage 100.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 350
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Urology	Frequency 350	Percentage 100.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

CPT Code: 52649
Specialty Society('s)

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor: **Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) (Do not report 52649 in conjunction with 52000, 52276, 52281, 52601, 53020, 55250)**

Sample Size: 52 Response Rate: (%): 63.4 Global Period: 90

Geographic Practice Setting %: Rural 9.09 Suburban 33.33 Urban 57.58

Type of Practice %:
12.12 Solo Practice
42.42 Single Specialty Group
18.18 Multispecialty Group
27.28 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: Our practice expense recommendations are based on the deliberation of a panel of urologists from various geographic and practice settings, including from private and academic practices.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities
Pre-operative work-up scheduling, which includes scheduling of history and physical exam, performance of vitals, exam, lab draw, chest x-ray, and EKG. Pre-admission testing scheduling and assessment by anesthesia. Scheduling of surgery with the operating room. Complete pre-service diagnostic & referral forms, provide pre-service education and consent and provide follow-up phone calls and prescriptions.

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities:
Admission to the hospital and all required paperwork and assessments. Discharge paperwork, provide home care instructions and teaching. Scheduling of post-operative clinic visits. Prepare and deliver prescriptions.

	A	B	C	D	E
1				52649	
2	April 2007 AMA Specialty Society Update Committee Recommendation			Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) (Do not report 5264X in conjunction with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD 090	L037D	RN/LPN/MTA		90
5	TOTAL CLINICAL LABOR TIME			0.0	171.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	12.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	99.0
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms				5
12	Coordinate pre-surgery services				20
13	Schedule space and equipment in facility				8
14	Provide pre-service education/obtain consent				20
15	Follow-up phone calls & prescriptions				7
16	Other Clinical Activity (please specify)				
17	**End:When patient enters office/facility for surgery/procedure**				
18	SERVICE PERIOD				
19	**Start: When patient enters office/facility for surgery/procedure**				
20	**Pre-service services**				
21	Review charts				
22	Greet patient and provide gowning				
23	Obtain vital signs				
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies				
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV				
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure				
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff				
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Discharge day management 99238 –12 minutes 99239 –15 minutes				12
40	Other Clinical Activity (please specify)				
41	**End: Patient leaves office**				
42	POST-SERVICE Period				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
45	*Office visits.*				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27		1
49	99213 36 minutes		36		2
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53	*Total Office Visit Time*			0	99
54	Other Activity (please specify)				
55	**End: with last office visit before end of global period**				
56	MEDICAL SUPPLIES	CMS Code	Unit		
57	Pack, minimum multi-specialty visit	SA048			3
58	Beaker, 250 ml	SL018			1
59	Paper, recording (roll per foot)	SK060			2
60	Ultrasound transmission gel	SJ062			1
61	Sanitizing cloth-wipe (surface, instrument, equipment)	SM022			1
62	Disinfectant spray (Transeptic)	SM012			1
63	Equipment	CMS Code			
64	table, power	EF032			1
65	uroflowmeter, digital, with chair	EQ259			1
66	ultrasound, noninvasive bladder control	EQ255			1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Laparoscopic Paravaginal Defect Repair

The CPT Editorial Panel revised one code and created two new codes to describe the three approaches to a paravaginal defect repair.

57284 and 57285
Code 57284 *Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse if performed); open abdominal approach* had been the code typically used for both the vaginal and abdominal approaches prior to its revision and the creation of new code 57285 *Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach*. The physician work of code 57284 was valued at 13.51 for the 2007 Medicare Physician Payment Schedule. The RUC agreed that the vaginal approach was less work than the abdominal approach, and with the estimated Medicare utilization from the specialty, the recommended work values result in a work neutral recommendation.

The low of the specialty's survey results for code 57284 of 14.25 was compared by the RUC, to its key reference code 57280 *Colpopexy, abdominal approach* (work RVU = 16.62) and was found to be similar in physician intensity, complexity, and physician time. However, the survey respondents indicated that the physician work value for 57284 was clearly lower than 57280 as its median survey value was 15.50. The specialty society recommended, and the RUC agreed, that the low of the survey results reflects the difference in the value from the reference code and accommodates for work neutrality. The RUC also confirmed that revised 57284, is similar in intra-service time and work RVU of CPT code 57260 *Combined anteroposterior colporrhaphy*. 57284 has 100 minutes of intra-service time and a recommended work RVU of 14.25, while 57260 has 90 minutes, and an RVW of 14.36. Code 57260 was revalued during the RUC's Third Five Year Review. **The RUC recommends a physician work relative value of 14.25 for CPT code 57284.**

The low of the specialty's survey results for code 57285 of 11.52 was compared by the RUC, to its key reference code 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele* (work RVU = 11.42), and was found to be physician work based on intensity, complexity, skill, and stress levels between the two services. The specialty's survey median indicated a physician work value of 13.25, however considering the physician time overall was less than the key reference code and work neutrality considerations, the RUC and the specialty concurred that the low of the specialty survey results reflects the physician work value for CPT code 57285 of 11.52. **The RUC recommends physician work relative value of 11.52 for CPT code 57285.**

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57423
The RUC reviewed the specialty society's survey results for this new technology laparoscopic approach to paravaginal defect repair, CPT code 57423 *Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach* (previously reported with an unlisted code) and agreed the survey results from the 35 obstetrics and gynecology physicians represented the appropriate physician work involved in this new service and showed a strong argument for accepting the survey median of 16.00 work RVUs for the service. The survey results were well distributed with the median and the physician time, complexity, and intensity measures indicated this new service was similar to its key reference service code 58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; (work RVU = 16.74). **The RUC recommends a specialty society's median survey physician work relative value of 16.00 for new code 57423.**

The specialty also standardized the physician time components from its survey results similar to other Obstetrics and Gynecological surgical procedures. The specialty standardized the pre-service time for evaluation to be 45 minutes, positioning to be 10 minutes, and pre-service scrub dress and wait to be 5 minutes. In addition, the procedures each were standardized to have one level three (99213) and one level two (99212) post operative evaluation and management office visits. The RUC agreed with these reductions in physician time from the survey results.

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for these facility only services. A practice expense spreadsheet is attached with recommendations for clinical labor staff time reflecting the PERC's 090 day global standard direct practice expense inputs.

The RUC recommends code 57423 be placed on the new technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲57284	OO1	Paravaginal defect repair (including repair of cystocele, ~~stress urinary incontinence, and/or incomplete vaginal prolapse~~ if performed); open abdominal approach (Do not report with 51840, 51841, 51990, 57240, 57260,57265, 58152, 58267)	090	14.25
●57285	OO2	Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach (Do not report 57285 in conjunction with 51990, 57240, 57260, 57265, 58267)	090	11.52

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Endoscopy				
●57423	OO3	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach (Do not report 57423 in conjuction with 49320, 51840, 51841, 51990, 57240, 57260, 58152, 58267)	090	16.00

1333

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57284 Tracking Number OO1 Specialty Society Recommended RVU: **14.25**
Global Period: 090 RUC Recommended RVU: **14.25**

CPT Descriptor: Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old G5P5 female patient presents with complaints of vaginal pressure and heaviness associated with prolonged standing. Her past history is significant for prior hysterectomy. Pertinent physical exam reveals no rectocele, enterocele, or perineal defect. Inspection of the anterior vaginal wall relaxation reveals a cystocele arising from paravaginal defects. An abdominal paravaginal defect repair is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes: taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; indications for the procedure and its appropriateness are reviewed; informed consent is obtained; the physician will admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; will check on the patient, and will review labs, x-rays and records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: An incision in made in the abdominal wall and access to the space of Retzius is obtained transperitoneally. The dissection is extended to expose the arcus tendineus fascia pelvis (ATFP) bilaterally. Several permanent sutures are passed along the anterior lateral vaginal sulcus (on each side) through the pubocervical fascia. These sutures are then brought through the obturator internus muscle, just above the ATFP, along its full length from the underside of the pubic symphysis down to the ischial spine. This is performed bilaterally. Then, guided by a retractor or instrument placed within the vaginal cavity, all sutures are tied sequentially to obliterate the defect. Fascia is closed and skin wounds are reapproximated.

Description of Post-Service Work: Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Robert L. Harris, MD, FACOG, George A. Hill, MD, FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists		
CPT Code:	57284		
Sample Size:	1000	**Resp N:** 38	**Response:** 3.8 %
Sample Type:	Convenience		

CPT Code: 57284

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		2.00	5.00	**15.00**	33.00	140.00
Survey RVW:		14.25	15.00	**15.50**	16.25	19.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**20.0**		
Intra-Service Time:		75.00	90.00	**100.00**	120.00	150.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**80.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 57284	
	Specialty Recommended
Physician Work RVU:	**14.25**
Pre-Service Evaluation Time:	**45.0**
Pre-Service Positioning Time:	**10.0**
Pre-Service Scrub, Dress, Wait Time:	**5.0**
Intra-Service Time:	**100.00**

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**39.0**	99211x **0.0** 12x **1.0** 13x **1.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
57280	090	16.62	**RUC Time**

CPT Descriptor Colpopexy, abdominal approach

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
63047	090	76,873	15.22	**RUC Time**

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; lumbar

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
36819	010	11,120	14.39	**RUC Time**

CPT Descriptor 2 Arteriovenous anastomosis, open; by upper arm basilic vein transposition

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 60.5 %

TIME ESTIMATES (Median)	CPT Code: 57284	Key Reference CPT Code: 57280	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	100.00	115.00	
Median Immediate Post-service Time	30.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	135.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**327.00**	**439.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.26	4.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	4.00
Urgency of medical decision making	3.22	3.17
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.74	4.61
Physical effort required	4.48	4.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.13	4.13
Outcome depends on the skill and judgment of physician	4.65	4.48

Estimated risk of malpractice suit with poor outcome	3.65	3.65

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.09	4.04
Intra-Service intensity/complexity	4.43	4.26
Post-Service intensity/complexity	3.75	3.70

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Urogynecologic Society (AUGS), disseminated the RUC survey to a targeted mailing list of 1000 members. Thirty-eight surveys were submitted electronically. ACOG staff summarized the data. A panel of physicians from ACOG and AUGS reviewed the results and drafted final recommendations.

The panel recommends acceptance of 14.25 RVWs .

The panel took these steps in reaching their conclusion:

1) Reviewed the results of the survery
2) Determined an IWPUT based on the recommended RVW
3) Compared the recommended RVW and IWPUT to the reference service code and other laparoscopic hysterectomy codes.

Review of Survey Results

The panel felt the survey respondents fairly estimated the intra-service time at 100 minutes. Pre-service positioning and scrub time may have been slightly overestimated by 5and 10 minutes respectively. The pre-services have been standardized throughout the new/revised codes to provide consistency among them. Additionally, the panel is of the opinion that the hospital visits were overstated by (1) 99231 and (1) 99212 post-operative office visit. Fifty-six minutes were deducted from the total survey time.

	Surveyed time	Consensus panel recommendation
Pre-service position	15	10
Pre-service scrub	20	5
Other Hospital Visits	80	60
Office Visits	62	46
TTL	177	121

It was the consensus of the panel that the median RVW value of 15.5 for this code appears to be high. Therefore, an RVW of 14.25, the 25 percentile was agreed upon. Though this value is higher than the current RVW for 57284 of 13.51, it must be noted that the current code encompasses both the vaginal and the abdominal approaches. The surveys

were consistent in describing lower work for the vaginal approach, and higher work for the abdominal approach. The values as proposed, will be budget neutral in that the lower valued service (the vaginal approach) will be removed from the original 57284, leaving only the higher work service in that code. It is estimated that the vaginal approach will be performed 25% of the time, while the remainder of the procedures currently being coded 57284, will be performed abdominally.

Also it should be noted that revised 57284, is similar in intra-service time and RVW of CPT code 57260 *Combined anteroposterior colporrhaphy*. The revised code has 100 minutes of intra-service time and a recommended RVW of 14.25, while 57260 has 90 minutes, and an RVW of 14.36. Code 57260 was revalued during the most recent 5-Year Review.

IWPUT Calculation – *ACOG/AUGS used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 1 (0.64)		0.64
Hospital visit 99232x1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99213 x 2 (.92)		1.84
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW		6.7645
Recommended RVW		14.25
Intra-RVW		7.4855
Intra-service time		100 minutes
IWPUT		**0.075**

A comparison of the paravaginal defect repair and reference service codes has been provided in Addendum A Excel spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 57284

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn, Urogynecologists, Gynocologist Oncologists How often? Sometimes

Specialty Urologists How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. The same PLI crosswalk should be used for the revised 57284 code, as the current code.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57285 Tracking Number OO2 Specialty Society Recommended RVU: **11.52**
Global Period: 090 RUC Recommended RVU: **11.52**

CPT Descriptor: Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old G5P5 female patient presents with complaints of vaginal pressure and heaviness associated with prolonged standing. Her past history is significant for prior hysterectomy. Pertinent physical exam reveals no rectocele, enterocele, or perineal defect. Inspection of the anterior vaginal wall relaxation reveals a cystocele arising from paravaginal defects. A vaginal paravaginal defect repair is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes: taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; indications for the procedure and its appropriateness are reviewed; informed consent is obtained; the physician will admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; will check on the patient, and will review labs, x-rays and records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: Vaginal access to the space of Retzius is obtained by opening the anterior vaginal wall and dissecting the bladder from the vaginal epithelium. The dissection is extended to expose the arcus tendineus fascia pelvis (ATFP) bilaterally. Several permanent sutures are passed along the anterior lateral vaginal sulcus (on each side) through the pubocervical fascia. These sutures are then brought through the obturator internus muscle, just above the ATFP, along its full length from the underside of the pubic symphysis down to the ischial spine. This is performed bilaterally. All sutures are tied sequentially to obliterate the defect. Vaginal incisions are reapproximated.

Description of Post-Service Work: Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 2-3 days. The patient is most often discharged on post op day 2 or 3 with instructions for follow-up care. The patient is reevaluated four times post operatively.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Robert L. Harris, MD, FACOG, George A. Hill, MD, FACOG				
Specialty(s):	American College of Obstetricians and Gynecologists				
CPT Code:	57285				
Sample Size:	1000	**Resp N:** 66	**Response:** 6.6 %		
Sample Type:	Convenience				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**

CPT Code: 57285

Service Performance Rate		2.00	8.00	**15.00**	40.00	100.00
Survey RVW:		11.52	12.75	**13.25**	14.12	14.44
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		45.00	50.00	**60.00**	65.00	90.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**71.0**	99211x **0.0** 12x **3.0** 13x **1.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 57285		
		Specialty Recommended
Physician Work RVU:		11.52
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		5.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 0.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	39.0	99211x 0.0 12x 1.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
57240	090	11.42	RUC Time

CPT Descriptor Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49560	090	42,742	11.84	RUC Time

CPT Descriptor 1 Repair initial incisional or ventral hernia; reducible

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
44950	090	6,222	10.52	RUC Time

CPT Descriptor 2 Appendectomy

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 28.7 %

TIME ESTIMATES (Median)	CPT Code: 57285	Key Reference CPT Code: 57240	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**267.00**	**307.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.21	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.37
Urgency of medical decision making	2.79	2.79
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.64	3.47
Physical effort required	4.16	3.32
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.89	3.37
Outcome depends on the skill and judgment of physician	4.37	3.74
Estimated risk of malpractice suit with poor outcome	3.74	3.53

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.58	3.37
Intra-Service intensity/complexity	4.21	3.47
Post-Service intensity/complexity	3.26	3.16

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Urogynecologic Society (AUGS), disseminated the RUC survey to a targeted mailing list of 1000 members. Sixty-six surveys were submitted electronically. ACOG staff summarized the data. A panel of physicians from ACOG and AUGS reviewed the results and drafted final recommendations.

The panel recommends acceptance of 11.52 RVWs .

The panel took these steps in reaching their conclusion:

1) Reviewed the results of the survery
2) Determined an IWPUT based on the recommended RVW
3) Compared the recommended RVW and IWPUT to the reference service code and other laparoscopic hysterectomy codes.

Review of Survey Results

The panel felt the survey respondents fairly estimated the intra-service time at 60 minutes. Pre-service evaluation the day proceeding the procedure, pre-service positioning and scrub time may have been overestimated by 15, 5and 10 minutes respectively. The pre-services have been standardized throughout the new/revised codes to provide consistency among them. Additionally, the panel is of the opinion that the hospital visits are understated by (1) 99231, and the postoperative office visits are overstated by (2) 99212 visits. Forty-two minutes were deducted from the total survey time.

	Surveyed time	Consensus panel recommendation
Pre-service evaluation day proceeding procedure	45	30
Pre-service evaluation day of procedure	15	15
Pre-service positioning	15	10
Pre-service scrub	15	5
Other Hospital Visits	60	80
Office Visits	71	39
TTL	221	179

It was the consensus of the panel that the median RVW value of 13.25 for this code appears to be high. Therefore, the 25% with an RVW of 11.52 was agreed upon. Though this value is lower than the current RVW for 57284 of 13.51, it must be noted that the current code encompasses both the vaginal and the abdominal approaches. The surveys were consistent in describing lower work for the vaginal approach, and higher work for the abdominal approach. The values as proposed, will be budget neutral in that the lower valued service (the vaginal approach) will be removed from the original 57284, leaving only the higher work service in that code. It is estimated that the vaginal approach will be performed 25% of the time, while the remainder of the procedures currently being coded 57284, will be performed abdominally.

Additionally, code 5728X1 has the same intra-service time as reference service code 57240, and an RVW of 11.52.

IWPUT Calculation – *ACOG/AUGS used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 2 (0.64)		1.28
Hospital visit 99232x1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99212x1 (0.45)		0.42
Office visit 99213 x 1 (.92)		0.92
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW		6.9045
Recommended RVW		11.52
Intra-RVW		4.6155
Intra-service time		60 minutes
IWPUT		**0.076**

A comparison of the paravaginal defect repair and reference service codes has been provided in Addendum A Excel spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 57284

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn, Urogynecologists, How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 57284

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57423 Tracking Number OO3 Specialty Society Recommended RVU: **16.0**
Global Period: 090 RUC Recommended RVU: **16.0**

CPT Descriptor: Paravaginal defect repair (including repair of cystocele, if performed); laparoscopic approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old G5P5 female patient presents with complaints of vaginal pressure and heaviness associated with prolonged standing. Her past history is significant for prior hysterectomy. Pertinent physical exam reveals no rectocele, enterocele, or perineal defect. Inspection of the anterior vaginal wall relaxation reveals a cystocele arising from paravaginal defects. A laparoscopic paravaginal defect repair is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes: taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; indications for the procedure and its appropriateness are reviewed; informed consent is obtained; the physician will admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; will check on the patient, and will review labs, x-rays and records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: Laparoscopic access to the space of Retzius is obtained transperitoneally. Multiple ancillary trocars are placed. The dissection is extended to expose the arcus tendineus fascia pelvis (ATFP) bilaterally. Several permanent sutures are passed along the anterior lateral vaginal sulcus (on each side) through the pubocervical fascia. These sutures are then brought through the obturator internus muscle, just above the ATFP, along its full length from the underside of the pubic symphysis down to the ischial spine. This is performed bilaterally. Then, guided by a retractor or instrument placed within the vaginal cavity, all sutures are tied sequentially with intra corporeal or extra corporeal knot tying techniques to obliterate the defect. Trocars are removed under direct vision and fascia closed. Skin wounds are reapproximated.

Description of Post-Service Work: Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 2 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Robert L. Harris, MD, FACOG, Craig J. Sobolewski, MD, FACOG, George A. Hill, MD, FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists		
CPT Code:	57423		
Sample Size: 1200	**Resp N:**	35	**Response:** 2.9 %

CPT Code: 57423

Sample Type: Convenience						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	3.00	**8.00**	15.00	75.00
Survey RVW:		15.00	15.50	**16.00**	16.97	18.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		110.00	120.00	**150.00**	150.00	180.00
Immediate Post Service-Time:	30.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	60.0	99231x **1.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	38.0	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	62.0	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 57423	
	Specialty Recommended
Physician Work RVU:	16.00
Pre-Service Evaluation Time:	45.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	5.0
Intra-Service Time:	150.00

Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 0.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	39.0	99211x 0.0 12x 1.0 13x 1.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58543	090	16.74	RUC Time

CPT Descriptor Laparoscopy, surgical, supracervical, for uterus greater than 250g;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58150	090	23,176	17.21	RUC Time

CPT Descriptor 1 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
63047	090	76,873	15.22	RUC Time

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; lumbar

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 31.4 %

TIME ESTIMATES (Median)	CPT Code: 57423	Key Reference CPT Code: 58543	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	150.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**357.00**	**350.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.45
Urgency of medical decision making	3.27	3.09
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.82	4.36
Physical effort required	4.73	4.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.45	4.27
Outcome depends on the skill and judgment of physician	4.82	4.09

Estimated risk of malpractice suit with poor outcome	4.27	4.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.82
Intra-Service intensity/complexity	4.64	4.36
Post-Service intensity/complexity	3.36	3.45

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Urogynecologic Society (AUGS) and the American Association of Gynecologic Laparoscopists (AAGL), disseminated the RUC survey to a targeted mailing list of 1200 members. Thirty-five surveys were submitted electronically. ACOG staff summarized the data. A panel of physicians from ACOG, AUGS and AAGL reviewed the results and drafted final recommendations.

The panel recommends acceptance of 16.00 RVWs .

The panel took these steps in reaching their conclusion:

1) Reviewed the results of the survery
2) Determined an IWPUT based on the recommended RVW
3) Compared the recommended RVW and IWPUT to the reference service code and other laparoscopic hysterectomy codes.

Review of Survey Results

The panel felt the survey respondents fairly estimated the intra-service time at 150 minutes. Pre-service positioning and scrub time may have been slightly overestimated by 5and 10 minutes respectively. The pre-services have been standardized throughout the new/revised codes to provide consistency among them. Additionally, the panel is of the opinion that the post-operative office visits were overstated by the respondents by (1) level two visit. Sixty-one minutes were deducted from the total survey time.

	Surveyed time	Consensus panel recommendation
Pre-service position	15	10
Pre-service scrub	15	5
Office Visits	62	46
TTL	92	31

It was the consensus of the panel that the median RVW value of 16.0 was in line with the other laparoscopic gynecology codes. The new code 5742X has 30 additional intra-service minutes than the reference service code 58543, *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g*; which has a RVW of 16.74.

IWPUT Calculation – *ACOG/AUGS/AAGL used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 1 (0.64)		0.64
Hospital visit 99232x1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99213 x 2 (.92)		1.84
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW		6.7645
Recommended RVW		16.0
Intra-RVW		9.2355
Intra-service time		150 minutes
IWPUT		**0.062**

A comparison of the paravaginal defect repair and reference service codes has been provided in Addendum A Excel spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Unlisted

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn, Urogynecologists, Gynecologic laparoscopists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 600
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Addendum A:
Paravaginal Defect Repair Comparison

	Ref Service 57280	Current 57284	Rvsd 57284	Ref Service 57240	57285	Ref Service 58543 (LSH)	57423
	Colpopexy, abd		PVDR, abd	Anterior colporraphy	PVDR, vag	greater 250g.	PVDR, lap
RVW	16.62	13.51	14.25	11.42	11.42	16.74	16.00
Intra-service RVW							
Intra-service	115	95	100	60	60	120	150
Other Hospital Time (OHT)							
99231 (20)	2	1	1	2	2	2	1
99232 (40)	1	1	1	1	1		1
99233 (55)	1						
Total OHT Time	135	60	60	80	80	40	60
Office Visits (OV)							
99212 (16)		1		1	1	1	
99213 (23)	2	3	2	1	1	2	2
Total OV Time	46	85	46	39	39	62	46
IWPUT	0.064	0.053	0.075	0.076	0.076	0.083	0.062

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
▲**57284**, Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for ▲57284 using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedure has (1) level two and (1) level three office visits. The standard times for a level two and level three office visits were used; 27 and 36 minutes respectively. A total of 63 minutes has been applied for post-service clinical labor activities time.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
▲**57285**, Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for 5742X using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedure has (1) level two and (1) level three office visits. The standard times for a level two and level three office visits were used; 27 and 36 minutes respectively. A total of 63 minutes has been applied for post-service clinical labor activities time.

CPT Code:57423
Specialty Society(s): American College of Obstetricians and Gynecologists

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
▲**57423**, Paravaginal defect repair (including repair of cystocele, if performed); laparoscopic approach

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for 57423 using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The The procedure has (1) level two and (1) level three office visits. The standard times for a level two and level three office visits were used; 27 and 36 minutes respectively. A total of 63 minutes has been applied for post-service clinical labor activities time.

	A	B	C	D	E	F	G	H	I
1				57284		57285		57423	
2	April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach		Paravaginal defect repair (including repair of cystocele, if performed; vaginal approach		Paravaginal defect repair (including repair of cystocele, if performed; laparoscopic approach	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD		RN/LPN/MTA		90		90		90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	135.0	0.0	135.0	0.0	135.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	60.0	0.0	60.0	0.0	60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	12.0	0.0	12.0	0.0	12.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D		0.0	63.0	0.0	63.0	0.0	63.0
9	PRE-SERVICE								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7
16	Other Clinical Activity (please specify)								
17	**End:When patient enters office/facility for surgery/procedure**								
18	SERVICE PERIOD								
19	**Start: When patient enters office/facility for surgery/procedure**								
20	**Pre-service services**								
21	Review charts								
22	Greet patient and provide gowning								
23	Obtain vital signs								
24	Provide pre-service education/obtain consent								
25	Prepare room, equipment, supplies								
26	Setup scope (non facility setting only)								
27	Prepare and position patient/ monitor patient/ set up IV								
28	Sedate/apply anesthesia								
29	**Intra-service**								
30	Assist physician in performing procedure								
31	**Post-Service**								
32	Monitor pt. following service/check tubes, monitors, drains								
33	Clean room/equipment by physician staff								
34	Clean Scope								
35	Clean Surgical Instrument Package								
36	Complete diagnostic forms, lab & X-ray requisitions								
37	Review/read X-ray, lab, and pathology reports								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
39	Discharge day management 99238	L037D	RN/LPN/MTA		12		12		12
40	Other Clinical Activity (please specify)								
41	**End: Patient leaves office**								
42	POST SERVICE PERIOD								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions								
45	*Office visits:*								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes								
48	99212 27 minutes	L037D	RN/LPN/MTA		1		1		1
49	99213 36 minutes	L037D	RN/LPN/MTA		1		1		1
50	99214 53 minutes								
51	99215 63 minutes								
52	Other								
53	*Total Office Visit Time*			0	63	0	63	0	63
54	Other Activity (please specify)								
55	**End: with last office visit before end of global period**								
56	MEDICAL SUPPLIES	CMS Code							
57	drape, non-sterile, sheet 40inX60in	SB006			2		2		2
58	kit, suture removal	SA031			1		1		1
59	pack, minimum multi-specialty visit	SA048			2		2		2
60	pack, pelvic exam	SA051			2		2		2
61	EQUIPMENT	CMS Code							
62	power table	E11003			1		1		1
63	fiberoptic exam light	E11006			1		1		1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Laparoscopic Total Hysterectomy

The CPT Editorial Panel created four new procedure codes to accurately reflect a total hysterectomy in which both the uterine cervix and body are completely detached from their surrounding support structures via a laparoscopic approach, and in which the vaginal cuff is sutured via a laparoscopic approach. Thus, with the exception of simply retrieving the specimen through the vagina, the entire procedure is performed laparoscopically.

Current codes reflect a procedure in which the attachments of the uterine body are secured laparoscopically and then the cervical attachments are secured via a vaginal route; both a laparoscopic and vaginal surgical approach are required for these procedures. The proposed codes describe accomplishing the complete detachment of the entire uterus and cervix via a laparoscopic approach. A vaginal approach is used only to retrieve the specimen. The vagina is closed via laparoscopic suturing techniques.

In February 2007, the RUC's Research Subcommittee had agreed that the two proposed base codes, 58570 *Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less* and 58572 *Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams* be surveyed utilizing a standard RUC survey instrument and an incremental add-on approach be used to develop RVU recommendations for the subsequent two codes in the family which both include the removal of tube(s) and/or ovary(s). These two subsequent codes are: 58571 *Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less; with removal of tubes and/or ovary(s)*, 58573 *Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams; with removal of tubes and/or ovary(s)*

58570 and 58572

The RUC reviewed the specialty society's survey results and key reference codes in order to provide proper rank order among the hysterectomy procedures. The RUC believed the survey results for new codes 58570 and 58572, of over 60 obstetrics and gynecologic physicians, represented the typical physician work involved with these new procedures. The RUC reviewed the specialty's key reference codes; 58550 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;* (work RVU = 14.97)
58552 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)* (work RVU = 16.78), and concurred that the specialty survey results provided the proper relative physician work value for codes 58570 and 58572. The agreed that the incremental difference between a vaginal approach and a total hysterectomy for a large uterus was less apparent than

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

that with a smaller uterus. The RUC considered the vaginal approach for a smaller uterus less overall work than the abdominal laproscopic approach.. The survey results in the intra-service period supported this relationship, where code 58570 has 20 additional minutes of intra-service time than 58550 and code 58571 has 15 more minutes of intra-service time than 58552. **The RUC recommends a relative physician work value of 15.75 for 58570 and 17.56 for 58572.**

58571 and 58573

Based on the agreed RUC Research Subcommittee methodology, the RUC added the incremental difference between 58550 and 58552 of 1.81 to arrive at a recommendation of (14.97 +1.81) 17.56 for 58571. In addition, the RUC added the incremental difference between codes; 58553 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;* (work RVU = 19.96) 58554 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU = 22.98) of 3.02 to 58572 (19.96 + 3.02) to arrive at 22.98 work RVUs for code 58573. The RUC and specialty concurred on that the physician work for codes 58571 and 58573 was identical codes 58553 and 58554 respectively. **The RUC recommends a physician work relative value for CPT code 58571 of 19.96 and 22.98 for 58573.**

Physician Time Components

Physician time components for codes 58571 and 58572 where derived by maintaining the same pre and post service work throughout the new family of codes and by adding an additional 15 minutes of intra-service work time for codes 58571 and 58573 above the surveyed time of 58570 and 58572 respectively.

The specialty also standardized the physician time components from its survey results similar to other Obstetrics and Gynecological surgical procedures. The specialty standardized the pre-service time for evaluation to be 45 minutes, positioning 10 minutes, and scrub dress and wait 5 minutes. In addition, the procedures each were standardized to have two level three and one level two post operative office visits. The RUC agreed with these reductions in physician time from the survey results. **The RUC recommends the following physician time components for 58570-58573.**

CPT Code	Pre-Evaluation	Pre Position	Pre-Srub, Dress, wait	Intra-Service	Immediate Post Time	99232	99231	99238	99212	99213	Total Time
58570	45	10	5	120	30	1	1	38	1	2	370
58571	45	10	5	135	30	1	1	38	1	2	385
58572	45	10	5	150	30	1	1	38	1	2	400
58573	45	10	5	165	30	1	1	38	1	2	415

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

New Technology: The RUC recommends this family of codes to be added to the new technology list. (Codes 58570, 58571, 58572, 58573)

Practice Expense

The RUC recommends no direct practice expense inputs in the non-facility setting for these facility only services. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service based on the 90 day global RUC standards.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
●58570	PP1	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	090	15.75
●58571	PP2	with removal of tube(s) and/or ovary(s) (Do not report 58570-58571 in conjunction with 49320, 57000, 57180, 57410, 58140-58146, 58150, 58545, 58546, 58561, 58661, 58670, 58671)	090	17.56
●58572	PP3	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	090	19.96
●58573	PP4	with removal of tube(s) and/or ovary(s) (Do not report 58570-58571 in conjunction with 49320, 57000, 57180, 57410, 58140-58146, 58150, 58545, 58546, 58561, 58661, 58670, 58671)	090	22.98
58550	PP5	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	090	14.97 (No Change)
58552	PP6	with removal of tube(s) and/or ovary(s)	090	16.78 (No Change)
58553	PP7	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;	090	19.96 (No Change)
58554	PP8	with removal of tube(s) and/or ovary(s) (Do not report 58550-58554 in conjunction with 49320, 57000, 57180, 57410, 58140-58146, 58545, 58546, 58561, 58661, 58670, 58671)	090	22.98 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58570 Tracking Number PP1 Specialty Society Recommended RVU: **15.75**
Global Period: 090 RUC Recommended RVU: **15.75**

CPT Descriptor: Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year-old G3P0 female has persistent cervical dysplasia. On physical examination she has an immobile, normal-sized uterus, and desires definitive therapy. She wishes to retain her ovaries. A total laparoscopic hysterectomy (TLH) is recommended without removal of the adnexae.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? .08%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; reviewing indications for the procedure and its appropriateness; obtain Informed consent; admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; check on the patient, and review labs, x-rays and records prior to the surgery; physician scrubs for procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: General anesthesia is induced, the patient is placed in the dorsal lithotomy position, and a surgical prep of the vagina and abdomen is performed. A foley catheter is placed transurethrally and a uterine manipulator is placed transcervically. Laparoscopy is performed through an umbilical camera port and second, third, and sometimes fourth incisions for accessory ports. The course of the ureters are identified transperitoneally or retroperitoneally, if needed. The bladder peritoneum is opened and the bladder is dissected off of the lower uterine segment. The utero-ovarian ligament and attachments of the uterus are then sequentially coagulated or ligated and then transected. The uterine arteries are skeletonized and control of this vasculature is obtained. An occluding device is placed within the vagina in order to preclude the escape of pneumoperitoneum, and anterior and posterior colpotomy incisions are performed. The uterus and cervix are removed through the vagina. Once the specimen has been completely removed, the occluding device is re-inserted, and the abdominal cavity is then re-inflated. Laparoscopic suture closure of the vaginal cuff is performed. Hemostasis is confirmed, the abdomen is deflated, and the instruments and trocars are removed. The trocar sites are closed with suture at the level of both the fascia and the skin.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family and other health care professionals (including wirtten and oral reports and orders); hospital visits to assees patient's status; removal of packs, drains, catheters, sutures, staples. Discharge management includes the physician's final examination of the patient, review of laboratory reports, instructions for continuing care, and preparation of the discharge records. In addition, three office visits are included in the global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Craig J Sobolewski, MD, FACOG, George A. Hill, MD, FACOG
Specialty(s):	American College of Obstetricians and Gynecologists
CPT Code:	58570

CPT Code: 58570

Sample Size: 500	Resp N: 61	Response: 12.2 %
Sample Type: Convenience		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**15.00**	35.00	220.00
Survey RVW:	14.97	15.00	**15.75**	17.00	20.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	90.00	105.00	**120.00**	120.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**40.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 58570	
	Specialty Recommended
Physician Work RVU:	15.75
Pre-Service Evaluation Time:	45.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	5.0
Intra-Service Time:	120.00
Immediate Post Service-Time: 30.00	

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58550	090	14.97	RUC Time

CPT Descriptor Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58150	090	23,176	17.21	RUC Time

CPT Descriptor 1 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
19303	090	16755	15.67	RUC Time

CPT Descriptor 2 Mastectomy, simple, complete

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 40.9 %

TIME ESTIMATES (Median)	CPT Code: 58570	Key Reference CPT Code: 58550	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	120.00	100.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**370.00**	**330.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.16	3.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.88
Urgency of medical decision making	3.60	3.48
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.96	4.28
Physical effort required	4.80	4.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.28	3.80
Outcome depends on the skill and judgment of physician	4.80	4.24

Estimated risk of malpractice suit with poor outcome	4.72	4.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.56	3.36
Intra-Service intensity/complexity	4.64	3.84
Post-Service intensity/complexity	3.16	3.08

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Association of Gynecologic Laparoscopists (AAGL), disseminated the RUC survey to a targeted list of 500 members. Sixty-one surveys were submitted electronically. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted final recommendations.

The panel recommends acceptance of 15.75 RVWs .

The panel took these steps in reaching their conclusion:

1) Reviewed the results of the survery
2) Determined an IWPUT based on the recommended RVW
3) Compared the recommended RVW and IWPUT to the reference service code and other laparoscopic hysterectomy codes.

Review of Survey Results

The panel felt the survey respondents fairly estimated the intra-service time at 120 minutes. Pre-service positioning and scrub time may have been slightly overestimated by 5 minutes each. The pre-service times have been standardized throughout the new codes to provide consistency among them. Ten minutes were deducted from the total survey time.

	Surveyed time	Consensus panel recommendation
Pre-service position	15	10
Pre-service scrub	10	5
TTL	25	15

It was the consensus of the panel that the median RVW value of 15.75 was in line with the other laparoscopic hysterectomy codes. Code 58570 has 20 additional intra-service minutes than 58550, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less*; which has an RVW of 14.97. Code 58570 has 25 additional intra-service minutes compared to 58541, *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;* which has an RVW of 14.57. A comparison of the laparoscopic hysterectomy codes has been provided in Addendum A Excel spreadsheet.

IWPUT Calculation – *ACOG/AAGL used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 1 (.64)		0.64
Hospital visit 99232x1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99212x1 (.45		0.45
Office visit 99213 x 2 (.92)		1.84
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW		7.2145
Recommended RVW		15.75
Intra-RVW		8.5355
Intra-service time		120 minutes
IWPUT		**0.071**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58550

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn & Gynecologic Laparoscopist, Gynecologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58571 Tracking Number PP2 Specialty Society Recommended RVU: **17.56**
Global Period: 090 RUC Recommended RVU: **17.56**

CPT Descriptor: Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year-old G3P3 female with chronic, anovulatory bleeding is evaluated for profound menorrhagia with anemia despite medical therapies. On physical examination she has a mobile, normal-sized uterus. The patient has a strong family history for malignancy and elects to have both her cervix and ovaries removed. A total laparoscopic hysterectomy (TLH) with bilateral salpingo-oophorectomy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; reviewing indications for the procedure and its appropriateness; obtain Informed consent; admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; check on the patient, and review labs, x-rays and records prior to the surgery; physician scrubs for procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: General anesthesia is induced, the patient is placed in the dorsal lithotomy position, and a surgical prep of the vagina and abdomen is performed. A foley catheter is placed transurethrally and a uterine manipulator is placed transcervically. Laparoscopy is performed through an umbilical camera port and second, third, and sometimes fourth incisions for accessory ports. The course of the ureters are identified transperitoneally or retroperitoneally, if needed. The bladder peritoneum is opened and the bladder is dissected off of the lower uterine segment. The location and course of the ureters are identified and the leaves of the broad ligament opened. The vasculature of the infundibulopelvic ligament is isolated, secured, and transected. The attachments of the uterus are then sequentially coagulated or ligated and then transected. An occluding device is placed within the vagina in order to preclude the escape of pneumoperitoneum, and anterior and posterior colpotomy incisions are performed. The patient is placed in the high lithotomy position and the surgeon removes the occluding device from the vagina, the pneumoperitoneum is allowed to escape, and the uterus and cervix are removed through the vagina. Once the specimen has been completely removed, the occluding device is re-inserted, and the abdominal cavity is then re-inflated. Laparoscopic suture closure of the vaginal cuff is performed. Hemostasis is confirmed, the abdomen is deflated, and the instruments and trocars are removed. The trocar sites are closed with suture at the level of both the fascia and the skin.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family and other health care professionals (including wirtten and oral reports and orders); hospital visits to assees patient's status; removal of packs, drains, catheters, sutures, staples. Discharge management includes the physician's final examination of the patient, review of laboratory reports, instructions for continuing care, and preparation of the discharge records. In addition, three office visits are included in the global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Craig J Sobolewski, MD, FACOG, George A. Hill, MD, FACOG

Specialty(s):	American College of Obstetricians and Gynecologists					
CPT Code:	58571					
Sample Size:	0	**Resp N:**	0	**Response:** 0.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:				**0.00**		
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 58571		
		Specialty Recommended
Physician Work RVU:		17.56
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		5.0
Intra-Service Time:		135.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58552	090	16.78	RUC Time

CPT Descriptor Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
49002	090	5,013	17.554	RUC Time

CPT Descriptor 1 Reopening of recent laparotomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
19303	090	16,755	15.67	RUC Time

CPT Descriptor 2 Mastectomy, simple, complete

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	CPT Code: 58571	Key Reference CPT Code: 58552	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	135.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**385.00**	**330.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		

Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Association of Gynecologic Laparoscopists (AAGL), reviewed the survey data of 58570 and developed a recommendation for 58571 based off of those data. As requested and agreed upon at the February 2007 RUC Research Subcommittee, the building block method was utilized using an incremental add-on approach in the valuation of this code. This method was utilized because of inconsistencies experienced in RVW values previously, when surveying the laparoscopic vaginal hysterectomy codes (LAVH) and the laparoscopic supracervical hysterectomy codes (LSH). The inconsistencies existed in the survey respondents recommended RVW values between the procedures with the *removal of tube(s) and/or ovary(s)* and those procedures where the tube(s) and/or ovary(s) were not removed.

The panel recommends acceptance of 17.56 RVWs .

The panel took these steps in reaching their conclusion:

1) Calculated the differences in RVW values between the LAVH codes (58550-58554) and the LSH codes (58541-58554) valued with and without the removal of tube(s) and/or ovary(s.
2) Calculated the differences between the intra-service times between the codes with and without the removal tube(s) and/or ovary(s).
3) Reviewed the relationship between the IWPUT in both families of laparoscopic hysterectomy codes (LAVH, LSH).
4) Developed a recommended RVW for 58571.

Review of Survey Results

After reviewing the differences in RVW values between the LAVH and LSH hysterectomy codes, the panel agreed on an increment of 1.81 RVW for the removal of tube(s) and ovary(s) for 58571. This value is the RVW increase between 58550 and 58552 (1.81RVW), and very close in value to 58541 and 58542 (1.86RVW). Therefore, based on the recommended median RVW for 58571 of 15.75, the panel recommends an RVW of 17.54 for code 58571 (15.75 + 1.81 = 17.56).

After calculating the differences in the intra-service times between the two established families of laparoscopic hysterectomy codes (LAVH and LSH), a conservative increment of 15 minutes was agreed upon by the panel.

Therefore, based on the intra-service time of 120 minutes for 58570, the panel recommends an intra-service time of 135 minutes for 58571.

The IWPUTs were reviewed between the new codes 58570, 58571, 58572 and 58573 after the valuation of these codes. The incremental increase of 1.81RVW and 15 additional minutes followed similar increases in IWPUTs between the LAVH and the LSH codes. Please refer to Addendum A Excel spreadsheet "Comparison of Laparoscopic Hysterectomy Procedures".

IWPUT Calculation – *ACOG/AAGL used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 1 (.64)		0.64
Hospital visit 99232x1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99212x1 (.45)		0.45
Office visit 99213 x 2 (.92)		1.84
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW		7.2145
Recommended RVW		17.56
Intra-RVW		10.346
Intra-service time		135 minutes
IWPUT		**0.077**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58552

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn, Gynecologic Oncologists, Gynecologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58572 Tracking Number PP3 Specialty Society Recommended RVU: **19.96**
Global Period: 090 RUC Recommended RVU: **19.96**

CPT Descriptor: Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year-old G32P2 female is evaluated for symptoms of dyspareunia and dysmenorrhea. On physical examination, she has an enlarged, but mobile, 14-week sized, enlarged uterus which is tender and consistent with an adenomyotic uterus. The patient elects a hysterectomy but wishes to retain her ovaries. A total laparoscopic hysterectomy (TLH) without removal of the adnexae is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; reviewing indications for the procedure and its appropriateness; obtain Informed consent; admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; check on the patient, and review labs, x-rays and records prior to the surgery; physician scrubs for procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: General anesthesia is induced, the patient is placed in the dorsal lithotomy position, and a surgical prep of the vagina and abdomen is performed. A foley catheter is placed transurethrally and a uterine manipulator is placed transcervically. Laparoscopy is performed through an umbilical camera port and second, third, and sometimes fourth incisions for accessory ports. The course of the ureters are identified transperitoneally or retroperitoneally, if needed. The bladder peritoneum is opened and the bladder is dissected off of the lower uterine segment. The utero-ovarian ligament and attachments of the uterus are then sequentially coagulated or ligated and then transected. If necessary, the uterine fundus may be debulked using a laparoscopic morcellator for benign disease, and, at times, the retroperitoneal spaces must be opened in order to identify the ureter. The uterine arteries are skeletonized and control of this vasculature is obtained. An occluding device is placed within the vagina in order to preclude the escape of pneumoperitoneum, and anterior and posterior colpotomy incisions are performed. The uterus and cervix are removed through the vagina. At times, vaginal morcellation of the specimen is necessary in order to accomplish removal. Once the specimen has been completely removed, the occluding device is re-inserted, and the abdominal cavity is then re-inflated. Laparoscopic suture closure of the vaginal cuff is performed. Hemostasis is confirmed, the abdomen is deflated, and the instruments and trocars are removed. The trocar sites are closed with suture at the level of both the fascia and the skin.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family and other health care professionals (including wirtten and oral reports and orders); hospital visits to assees patient's status; removal of packs, drains, catheters, sutures, staples. Discharge management includes the physician's final examination of the patient, review of laboratory reports, instructions for continuing care, and preparation of the discharge records. In addition, two office visits are included in the global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Craig J. Sobolewski, MD, FACOG, George A. Hill, MD, FACOG

Specialty(s):	American College of Obstetricians and Gynecologists		
CPT Code:	58572		
Sample Size:	1000	**Resp N:** 101	**Response:** 10.1 %
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	20.00	50.00
Survey RVW:	17.50	20.00	**20.02**	21.00	23.17
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	90.00	120.00	**150.00**	150.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**60.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**46.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 58572	
	Specialty Recommended
Physician Work RVU:	19.96
Pre-Service Evaluation Time:	45.0
Pre-Service Positioning Time:	10.0
Pre-Service Scrub, Dress, Wait Time:	5.0
Intra-Service Time:	150.00
Immediate Post Service-Time:	30.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58553	090	19.96	RUC Time

CPT Descriptor Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
35141	090	4,076	20.83	RUC Time

CPT Descriptor 1 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femorsis, superficial femoral)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
38100	010	4,085	19.47	RUC Time

CPT Descriptor 2 Splenectomy; total (separate procedure)

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 20.7 %

TIME ESTIMATES (Median)	CPT Code: 58572	Key Reference CPT Code: 58553	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	150.00	150.00	
Median Immediate Post-service Time	30.00	37.50	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**400.00**	**391.50**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.04	3.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.65
Urgency of medical decision making	3.27	3.27

Technical Skill/Physical Effort (Mean)		
Technical skill required	4.88	4.06
Physical effort required	4.53	3.92

Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.29	3.86
Outcome depends on the skill and judgment of physician	4.84	4.29

Estimated risk of malpractice suit with poor outcome	4.39	4.10

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.71	3.39
Intra-Service intensity/complexity	4.57	4.02
Post-Service intensity/complexity	3.18	3.10

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Association of Gynecologic Laparoscopists (AAGL), disseminated the RUC survey to a targeted mailing list of 500 members. One hundred and one surveys were submitted electronically. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted final recommendations.

The panel recommends acceptance of 19.96 RVWs .

The panel took these steps in reaching their conclusion:

1) Reviewed the results of the survery
2) Determined an IWPUT based on the recommended RVW
3) Compared the recommended RVW and IWPUT to the reference service code and other laparoscopic hysterectomy codes.

Review of Survey Results

The panel felt the survey respondents fairly estimated the intra-service time at 150 minutes. Pre-service positioning and scrub time may have been slightly overestimated by 5 minutes and 10 minutes respectively. The pre-services have been standardized throughout the new codes to provide consistency among them. Fifteen minutes were deducted from the total survey time.

	Surveyed time	Consensus panel recommendation
Pre-service position	15	10
Pre-service scrub	15	5
TTL	30	15

It was the consensus of the panel that the RVW value of 19.96 was consistent with 58553. The new code 58572 has the same intra-service time as 58553, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250*, which has an RVW of 19.96. Therefore, the panel agreed on the same RVW value as 58553, instead of the median RVW of 20.02. A comparison of the laparoscopic hysterectomy codes has been provided in Addendum A Excel spreadsheet.

IWPUT Calculation – *ACOG/AAGL used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 1 (.64)		0.64
Hospital visit 99232x 1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99212x1 (.45)		0.45
Office visit 99213 x 2 (.92)		1.84
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW		7.214
Recommended RVW		19.96
Intra-RVW		12.746
Intra-service time		150 minutes
IWPUT		**0.085**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58553

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn & Gynecologic Laparoscopists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 750

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 75
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58573 Tracking Number PP4 Specialty Society Recommended RVU: **22.98**
Global Period: 090 RUC Recommended RVU: **22.98**

CPT Descriptor: Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46 year-old G32P2 female is evaluated for profound menorrhagia with anemia despite daily medical therapy. On physical examination, she has an irregular, mobile, 14-week sized, leiomyomatous uterus. The patient elects a hysterectomy and wishes to have her ovaries removed. A total laparoscopic hysterectomy (TLH) with bilateral salpingo-oophorectomy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; reviewing indications for the procedure and its appropriateness; obtain Informed consent; admit the patient to the hospital; prepare the hospital records and chart in accordance with hospital policy; check on the patient, and review labs, x-rays and records prior to the surgery; physician scrubs for procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work: General anesthesia is induced, the patient is placed in the dorsal lithotomy position, and a surgical prep of the vagina and abdomen is performed. A foley catheter is placed transurethrally and a uterine manipulator is placed transcervically. Laparoscopy is performed through an umbilical camera port and second, third, and sometimes fourth incisions for accessory ports. The course of the ureters are identified transperitoneally or retroperitoneally, if needed. The bladder peritoneum is opened and the bladder is dissected off of the lower uterine segment. If necessary, the uterine fundus may be debulked using a laparoscopic morcellator for benign disease, and, at times, the retroperitoneal spaces must be opened in order to identify the ureter. The vasculature of the infundibulopelvic ligament is isolated, secured, and transected. The attachments of the uterus are then sequentially coagulated or ligated and then transected. If necessary, steps may be taken to debulk the size of the uterus in order to safely continue to dissect the uterine attachments. The uterine arteries are skeletonized and control of this vasculature is obtained. An occluding device is placed within the vagina in order to preclude the escape of pneumoperitoneum, and anterior and posterior colpotomy incisions are performed. The uterus and cervix are removed through the vagina. At times, vaginal morcellation of the specimen is necessary in order to accomplish removal. Once the specimen has been completely removed, the occluding device is re-inserted, and the abdominal cavity is then re-inflated. Laparoscopic suture closure of the vaginal cuff is performed. Hemostasis is confirmed, the abdomen is deflated, and the instruments and trocars are removed. The trocar sites are closed with suture at the level of both the fascia and the skin.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family and other health care professionals (including wirtten and oral reports and orders); hospital visits to assees patient's status; removal of packs, drains, catheters, sutures, staples. Discharge management includes the physician's final examination of the patient, review of laboratory reports, instructions for continuing care, and preparation of the discharge records. In addition, two office visits are included in the global period.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Craig J. Sobolewski, MD, FACOG, George A. Hill, MD, FACOG				
Specialty(s):	American College of Obstetricians and Gynecologists				
CPT Code:	58573				
Sample Size: 0	**Resp N:** 0	**Response:** 0.0 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:			**0.00**		
Immediate Post Service-Time:	**0.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 58573		
		Specialty Recommended
Physician Work RVU:		22.98
Pre-Service Evaluation Time:		45.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		5.0
Intra-Service Time:		165.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	60.0	99231x 1.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	62.0	99211x 0.0 12x 1.0 13x 2.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
58554	090	22.98	RUC Time

CPT Descriptor Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
44140	090	43,076	22.46	RUC Time

CPT Descriptor 1 Colectomy, partial; with anastomosis

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
35141	090	4,076	20.83	RUC Time

CPT Descriptor 2 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femorsis, superficial femoral)

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	CPT Code: 58573	Key Reference CPT Code: 58554	Source of Time RUC Time
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	165.00	167.50	
Median Immediate Post-service Time	30.00	37.50	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**415.00**	**425.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		
Technical Skill/Physical Effort (Mean)		
Technical skill required		
Physical effort required		
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		

Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG), in collaboration with the American Association of Gynecologic Laparoscopists (AAGL), reviewed the survey data of 58573 and developed a recommendation for 58573 based off of those data. As requested and agreed upon at the February 2007 RUC Research Subcommittee, the building block method was utilized using an incremental add-on approach in the valuation of this code. This method was utilized because of inconsistencies experienced in RVW values previously when surveying the laparoscopic vaginal hysterectomy codes (LAVH) and the laparoscopic supracervical hysterectomy codes (LSH). The inconsistencies existed in the survey respondents recommended RVW values between the procedures with the *removal of tube(s) and/or ovary(s)* and those procedures where the tube(s) and/or ovary(s) were not removed.

The panel recommends acceptance of 22.98 RVWs .

The panel took these steps in reaching their conclusion:

1) Calculated the differences in RVW values between the LAVH codes (58550-58554) and the LSH codes (58541-58554) valued with and without the removal of tube(s) and/or ovary(s).
2) Calculated the differences between the intra-service times between the codes with and without the removal tube(s) and/or ovary(s).
3) Reviewed the relationship between the IWPUT in both families of laparoscopic hysterectomy codes (LAVH, LSH).
4) Developed a recommended RVW for 585XX4.

Review of Survey Results

After reviewing the differences in RVW values between the LAVH, LSH and the vaginal hysterectomy codes, the panel agreed on an increment of 3.02 RVW for the removal of tube(s) and ovary(s). This is the RVW increase between 58553 and 58554. Therefore, based on the recommended median RVW for 58573 of 19.96, the panel recommends an RVW of 22.98 for code 58572 (19.96 + 3.02 = 22.98).

After calculating the differences between the intra-service times between the two established families of laparoscopic hysterectomy codes (LAVH and LSH), a conservative increment of 15 minutes was agreed upon by the panel. Therefore, based on the intra-service time of 150 minutes for 58572, the panel recommends an intra-service time of 165 minutes for 58573.

The IWPUTs were reviewed between the new codes 58570, 58571, 58572 and 58573 after the valuation of these codes. The incremental increases of 3.02RVW and 15 additional minutes followed similar increases in IWPUTs between the LAVH and the LSH codes. Please refer to the Addendum A Excel spreadsheet "Comparison of Laparoscopic Hysterectomy Procedures".

IWPUT Calculation – *ACOG/AAGL used the standard RUC method for calculation the IWPUT*

Hospital visit 99231x 1 (.64)		0.64
Hospital visit 99232x1 (1.06)		1.06
Discharge 99238		1.28
Office visit 99212x1 (.45)		0.45
Office visit 99213 x 2 (.92)		1.84
Pre-service, day prior (0.0224 x 30 min)		0.672
Pre-service, same day (0.0224 x 25 min)		0.56
Scrub, dress, wait (0.0081 x 5 min)		0.0405
Post service (0.0224 x 30 min)	+	0.672
Total pre- & post- RVW	7.2145	
Recommended RVW		22.98
Intra-RVW		15.766
Intra-service time		165 minutes
IWPUT		**0.088**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58554

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn, Gynecologic Laparoscopists, Gynecologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1250
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Addendum A (Additional Rationale)
585XX1, 585XX2, 585XX3, 585XX4

Comparison of Laparoscopic Hysterectomy Procedures

	58550 LAVH 250g or less	58552 LAVH 250g or less w t/o	58553 LAVH greater 250g	58554 LAVH greater 250g w t/o	58541 LSH 250g or less	58542 LSH 250g or less w t/o	58543 LSH greater 250g	58544 LSH greater 250g w t/o	58570 LTH 250g or less	58571 LTH 250g or less w t/o	58572 LTH greater 250g	58573 LTH greater 250g w t/o
RVW	14.97	16.78	19.96	22.98	14.57	16.43	16.74	18.24	15.75	17.56	19.96	22.98
Intra-service RVW	8.1755	10.626	13.028	15.598	7.776	9.6355	9.946	11.446	8.536	10.346	12.746	15.766
Intra-service	100	120	150	167.5	95	110	120	135	120	135	150	165
Other Hospital Time (OHT)												
99231 (20)	2	1	1	1	2	2	2	2	1	1	1	1
99232 (40)	0	0	1	1	0	0	0	0	1	1	1	1
Total OHT Time	40	20	60	60	40	40	40	40	60	60	60	60
Office Visits (OV)												
99212 (16)	1	1		1	1	1	1	1	1	1	1	1
99213 (23)	2	2	2	2	2	2	2	2	2	2	2	2
Total OV Time	62	62	46	62	62	62	62	62	62	62	62	62
IWPUT	0.082	0.089	0.087	0.093	0.082	0.088	0.083	0.085	0.071	0.077	0.085	0.096

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
58570, Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less;

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for 58570 using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedure has (1) level two and (2) level three office visits. The standard times for a level two and level three office visit were used, 27 and 36 minutes respectively. A total of 99 minutes has been applied for post-service clinical labor activities time.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
58571, Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less; with removal of tube(s) and ovary(s)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for 58571 using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedure has (1) level two and (2) level three office visits. The standard times for a level two and level three office visit were used, 27 and 36 minutes respectively. A total of 99 minutes has been applied for post-service clinical labor activities time.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
58572, Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams;

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for 58572 using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedure has (1) level two and (2) level three office visits. The standard times for a level two and level three office visit were used, 27 and 36 minutes respectively. A total of 99 minutes has been applied for post-service clinical labor activities time.

AMA/Specialty Society Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:
58573, Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and ovary(s)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ACOG developed practiced expense recommendations for 58573 using a consensus panel format. ACOG's members familiar with practice expense participated in this process through emails. Members of ACOG's Committee on Coding and Nomenclature finalized the recommendations through emails.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA (CMS Labor Supply code L037D) completes pre-service diagnostic and referral forms, coordinates pre-surgery services schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

The standard 12 minutes are applied for this inpatient procedure for discharge day management services.

Post-Service Clinical Labor Activities:

The procedure has (1) level two and (2) level three office visits. The standard times for a level two and level three office visit were used, 27 and 36 minutes respectively. A total of 99 minutes has been applied for post-service clinical labor activities time.

	A	B	C	D	E	F	G
1				58570		58571	
2	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less;		Laparoscopy, surgical, with total hysterectomy, for 250 grams or less; with removal of tube(s) and/or ovary(s)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD		RN/LPN/MTA		90		90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	171.0	0.0	171.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	60.0	0.0	60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	12.0	0.0	12.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D		0.0	99.0	0.0	99.0
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
16	Other Clinical Activity (please specify)						
17	End:When patient enters office/facility for surgery/procedure						
18	SERVICE						
19	Start: When patient enters office/facility for surgery/procedure						
20	Pre-service services						
21	Review charts						
22	Greet patient and provide gowning						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	Intra-service						
30	Assist physician in performing procedure						
31	Post-Service						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		12		12
40	Other Clinical Activity (please specify)						
41	End: Patient leaves office						
42	POST-SERVICE						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes						
48	99212 27 minutes	L037D	RN/LPN/MTA		1		1
49	99213 36 minutes				2		2
50	99214 53 minutes	L037D	RN/LPN/MTA				
51	99215 63 minutes						
52	Other						
53	*Total Office Visit Time*			0	99	0	99
54	Other Activity (please specify)						
55	End: with last office visit before end of global period						
56	MEDICAL SUPPLIES	CMS Code					
57	drape, non-sterile, sheet 40inX60in	SB006			3		3
58	kit, suture removal	SA031			1		1
59	pack, minimum multi-specialty visit	SA048			3		3
60	pack, pelvic exam	SA051			3		3
61	EQUIPMENT	CMS Code					
62	power table	E11003			1		1
63	fiberoptic exam light	E11006			1		1

	A	B	C	H	I	J	K
1				58572		58573	
2	**Meeting Date: April 2007** **AMA/Specialty Society RVS Update Committee Recommendation**			**Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams;**		**Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)**	
3	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**		**RN/LPN/MTA**		**90**		**90**
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**171.0**	**0.0**	**171.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**60.0**	**0.0**	**60.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**0.0**	**12.0**	**0.0**	**12.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**		**0.0**	**99.0**	**0.0**	**99.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	**L037D**	**RN/LPN/MTA**		**5**		**5**
12	Coordinate pre-surgery services	**L037D**	**RN/LPN/MTA**		**20**		**20**
13	Schedule space and equipment in facility	**L037D**	**RN/LPN/MTA**		**8**		**8**
14	Provide pre-service education/obtain consent	**L037D**	**RN/LPN/MTA**		**20**		**20**
15	Follow-up phone calls & prescriptions	**L037D**	**RN/LPN/MTA**		**7**		**7**
16	Other Clinical Activity (please specify)						
17	**End:When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure**						
20	**Pre-service services**						
21	Review charts						
22	Greet patient and provide gowning						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure						
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 –12 minutes	**L037D**	**RN/LPN/MTA**		**12**		**12**
40	Other Clinical Activity (please specify)						
41	**End: Patient leaves office**						
42	**POST-SERVICE PERIOD**						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes						
48	99212 27 minutes	**L037D**	**RN/LPN/MTA**		**1**		**1**
49	99213 36 minutes				**2**		**2**
50	99214 53 minutes	**L037D**	**RN/LPN/MTA**				
51	99215 63 minutes						
52	Other						
53	*Total Office Visit Time*			**0**	**99**	**0**	**99**
54	Other Activity (please specify)						
55	**End: with last office visit before end of global period**						
56	**SUPPLIES**	**CMS Code**					
57	drape, non-sterile, sheet 40inX60in	**SB006**			**3**		**3**
58	kit, suture removal	**SA031**			**1**		**1**
59	pack, minimum multi-specialty visit	**SA048**			**3**		**3**
60	pack, pelvic exam	SA051			**3**		**3**
61	**EQUIPMENT**	**CMS Code**					
62	power table	**E11003**			**1**		**1**
63	fiberoptic exam light	**E11006**			**1**		**1**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Vitrectomy with Epiretinal Membrane Stripping

CPT code 67038, *Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping*, was identified by CMS in 2005 as a potentially mis-valued service and placed in the Five-Year Review. The code was referred to CPT for refinement because the code was being used to report several dinstinct procedures which had evolved over the past decade for treatment of retinal-vitreal disease. The CPT Editorial Panel deleted code 67038 and created four new codes to describe the work performed in code 67038. The new codes are:

- Code 67041, V*itrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)*, which describes vitrectomy surgery to remove a cellular membrane from the anterior surface of the macula (center of the retina), e.g. macular pucker.
- Code 67042, *Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)*, which describes vitrectomy with removal of the internal limiting membrane (non-cellular, very adherent and microscopically thin) from the surface of the macula requiring greater time and skill and with considerable risk of damaging the macula. This procedure is performed for the repair of macular holes and for treatment of diabetic macular edema. This service may include the injection of therapeutic intraocular gas for macular hole repair.
- Code 67043, V*itrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation*, which describes vitrectomy for the repair of complex retinal detachment combined with code 67108. The typical patient has proliferative vitreoretinopathy or diabetic traction producing a retinal detachment, which may be performed for management of a giant retinal tear.
- Code 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of > 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens*, which describes vitrectomy with the removal of a neovascular membrane from the subretinal space. The procedure requires a vitrectomy and a retinotomy. Currently no single CPT procedure accurately describes the

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

surgical repair of complex retinal detachment using this technique, so surgeons used codes 67038, (work RVU = 23.30) and 67108, *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique* (work RVU = 22.49). CMS has expressed concern that the combination of the retinal detachment repair and vitrectomy codes resulted, even with a multiple procedure modifier, in a total work RVU that was overvalued.

The RUC considered new code 67041 and discussed the survey results in comparison with the key reference service code, 67108, *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). The reference service code has a significantly higher intra-service time as compared to the surveyed code, 191 minutes and 62.50 minutes, respectively. While the physician time differed, the RUC agreed that although the reference code has more time than the surveyed code, both codes have similar mental effort and judgment, identical psychological stress and increased technical skill and physical effort of the surveyed code made it a suitable reference service. Due to the difference in total time, the RUC agreed with the specialty society recommendation of 19.00 work RVUs. The RUC considered an additional reference service, 67218, *Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)* (work RVU = 20.22, intra-service time = 60 minutes). Additionally, the recommendation maintains appropriate rank order within the family of services. **The RUC recommends a work RVU of 19.00 pre-service time of 35 minutes, intra-service time of 62.50 minutes, and post-service time of 17.50 minutes for code 67041.**

1402

The RUC discussed new code 67042 and reviewed the survey results in comparison with the key reference service code, 67108 *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). The key reference service has significantly higher intra-service time than 67042 survey results, 191 minutes and 85 minutes, respectively. However, the reference service code requires less technical skill, physical effort, and psychological stress. The RUC also noted that the use of vitreous substitute results in a 30 to 40 percent incidence of post-operative elevated intraocular pressure requiring treatment with topical and systemic medications, and in some instances code 65805, *Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous* (work RVU = 1.91) or code 67015, *Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)* (work RVU = 7.00) are required. Neither of these procedures related to the initial surgery, which are performed in the office and would be billable during the global period, but both have significant physician work associated with them. The reference service work RVU of 22.49 is significantly higher than the surveyed median, therefore the RUC agreed that the 25th percentile of the survey results was appropriate. **The RUC recommends a work RVU of 22.13, pre-service time of 35, intra-service time of 85, and post-service time of 15 for code 67042.**

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The RUC considered new code 67043 and discussed the survey results in comparison with the key reference service code, 67108 *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). The key reference service has contains more intra-service time than the surveyed code, 191 minutes and 90 minutes, respectively. However, because of the patient expectation of perfect vision, the surveyed code requires greater mental effort and judgment, technical skill, psychological stress, and intensity and complexity. The RUC agreed that the 25th percentile of the survey results was too low. Because the service is more complex and contains one additional post-operative visit than 67042, which also relied on 67108 as the key reference service, the RUC added 0.94 RVUs to the survey median, commensurate with one 99213, to account for additional work and to maintain rank order within the family. **The RUC recommends a work RVU of 22.94, pre-service time of 35, intra-service time of 90, and post-service time of 20 for code 67043.**

The RUC discussed new code 67113 and reviewed the survey results in comparison with the key reference service code, 67108 *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). This service is the most complex of the four codes in the series of vitrectomy procedures and is performed only by fellowship trained retina surgeons. Code 67113 combines pars plana vitrectomy with a number of other surgical procedures that may include scleral buckling, dissection of periretinal scar tissue, retinal repositioning, retinopexy with laser or cryopexy, cataract extraction and installation of a vitreous substitute, either an expansible gas or silicon oil. The survey found a median wRVU of 27.00 and a 25th percentile of 25.00. The median intra-service time was 130 minutes. All of the intensity complexity measures were higher than to perform this procedure than the surveyed reference code. The need for retinal tamponade with a vitreous substitute results in a 30% incidence of elevated intraocular pressure requiring treatment with topical and systemic medications or in some cases the in-office removal of fluid from the eye by paracentesis (65805) or by vitreous tap (67015). Neither of these procedures, would be billable during the global period, but both have significant physician work associated with them. Based on survey responses, seven 99213 post-operative visits are required. The surveyed code requires greater mental effort, judgment, technical skill, physical effort, and psychological stress than reference code 67108, which has a value of 22.49. As such, the RUC agreed that the 25th percentile of the survey results was appropriate. **The RUC recommends a work RVU of 25.00, pre-service time of 35, intra-service time of 130, and post-service time of 20 for code 67113.**

The coding changes do not represent new work and the RUC sought to maintain work neutrality within the family. Therefore, the RUC reviewed an analysis of its recommended work RVUs and projected Medicare utilization to assure that the changes are work neutral.

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Practice Expense
The RUC reviewed the practice expense and recommended the standard 090 day global inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
67036		Vitrectomy, mechanical, pars plana approach;	090	13.09 (No Change)
●67041	I1	with removal of preretinal cellular membrane (eg, macular pucker)	090	19.00
D 67038		~~with epiretinol membrane stripping~~	090	N/A
67039		*with focal endolaser photocoagulation*	090	16.39 (No Change)
67040		*with endolaser panretinal photocoagulation*	090	19.23 (No Change)
●67042	I2	with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), ~~may~~ includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) ~~therapeutic gas injection~~	090	22.13
●67043	I3	with removal of subretinal membrane (eg, choroidal neovascularization), ~~may~~ includes, if performed, ~~intraocular gas injection~~ intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation (For the use of vitrectomy in retinal detachment surgery, use 67108)	090	22.94
67108	I4	Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	090	22.49 (no change)

1404

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●67113	I5	Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of > 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens (For use of vitrectomy in retinal detachment surgery, see 67036-67043)	090	25.00

1405

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67041 Tracking Number Specialty Society Recommended RVU: **19.00**
Global Period: 090 RUC Recommended RVU: **19.00**

CPT Descriptor: Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old woman with reduced vision and metamorphopsia due to macular pucker

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 33%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review patient record. Review diagnostic testing (fundus photography, extended ophthalmoscopy, fluorescein angiography, and optical coherence tomography). Obtain consent. Write preoperative orders for medications, pupillary dilation, and antibiotic prophylaxis. Select appropriate anesthesia. Discuss surgery again with patient and family. Scrub and gown. Perform surgical 'time out' with the OR team. After appropriate anesthesia is administered, the eye is prepped and draped.

Description of Intra-Service Work: The conjunctiva is opened both nasally and temporally. The sclera is entered with a microvitreoretinal (MVR) blade inferotemporally and an infusion cannula is sutured to the sclera . A balanced salt infusion fluid is used to maintain intraocular pressure. The sclera is entered with a MVR blade both superonasally and superotemporally to allow passage of the vitrector and the fiber optic light source through separate incisions. The central vitreous is removed, and vitreous shaved as close as is safe to the vitreous base. Then an MVR blade is barbed, and under high magnification of the operating microscope, en edge of the cellular membrane is gently elevated. When sufficient tissue is mobilized, an intraocular micro forceps is introduced and used to further elevate and then permanently remove the cellular membrane. The peripheral fundus is examined for possible retinal tears. The wounds are inspected and the conjunctival approximated over the scleral incisions. Antibiotics and cycloplegics are applied to the operated eye.

Description of Post-Service Work: Apply sterile dressing. Instruct recovery room staff on correct positioning of patient. Write post-operative orders. Chart progress note. Discuss surgical procedure and post op instructions with patient and family. Dictate operative note. Communicate with referring physician.The patient is typically seen post-operatively at one day, one week, 3 weeks, 6 weeks and 10 weeks. At each exam the visual acuity is measured, a complete eye exam performed including assessment of the anterior segment, the crystalline lens (or implant), the intraocular pressure, and a full dilated fundus exam is performed.. Activity and restrictions are reviewed. Medications are tapered or changed as appropriate. Progress is discussed with referring physician. Progress notes placed in the medical record..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007		
Presenter(s):	Stephen Kamenetzky, MD and Trex Topping, MD		
Specialty(s):	Ophthalmology		
CPT Code:	67041		
Sample Size:	165	**Resp N:** 36	**Response:** 21.8 %
Sample Type:	Random		

CPT Code: 67041

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	20.00	**40.00**	73.75	157.00
Survey RVW:		14.25	19.75	**23.30**	23.75	37.79
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		15.00	45.00	**62.50**	90.00	110.00
Immediate Post Service-Time:	**17.50**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**115.0**	99211x **0.0** 12x **0.0** 13x **5.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 67041	
	Specialty Recommended
Physician Work RVU:	**19.00**
Pre-Service Evaluation Time:	**10.0**
Pre-Service Positioning Time:	**10.0**
Pre-Service Scrub, Dress, Wait Time:	**15.0**
Intra-Service Time:	**62.50**

Immediate Post Service-Time:	**17.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**115.0**	99211x **0.0** 12x **0.0** 13x **5.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67108	090	22.49	**Harvard Time**

CPT Descriptor Repair detached retina

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
22840	090	15,975	12.52	**RUC Time**

CPT Descriptor 1 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
24430	090	641	12.79	**Harvard Time**

CPT Descriptor 2 Repair of nonunion or malunion, humerus; without graft (eg, compression technique)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 36.1 %

TIME ESTIMATES (Median)	CPT Code: 67041	Key Reference CPT Code: 67108	Source of Time Harvard Time
Median Pre-Service Time	35.00	40.00	
Median Intra-Service Time	62.50	191.00	
Median Immediate Post-service Time	17.50	34.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	25.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	115.0	110.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**249.00**	**438.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.85	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.85
Urgency of medical decision making	3.38	3.85
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.85	4.69
Physical effort required	4.23	4.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.54	4.54
Outcome depends on the skill and judgment of physician	4.77	4.77

Estimated risk of malpractice suit with poor outcome	4.15	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.92	4.23
Intra-Service intensity/complexity	4.38	4.69
Post-Service intensity/complexity	4.08	4.38

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 67038 was originally submitted by CMS for the third Five Year review because it had never been RUC valued. Survey data were collected last year. The expert consensus panel of the AAO Health Policy Committee reviewed the data for the service and determined that it would be difficult to value because the code was being used to report several distinct procedures which had evolved over the last decade for the treatment of retinal-vitreal disease. This resulted in confusion regarding the code during the original survey. AAO requested that the RUC refer the code to CPT and the RUC agreed. CPT created a new family of codes and this family is being surveyed. All of the procedures require complex surgical technology to perform. Although in some cases improved technology may result in the work being easier, in this instance the new technology has raised expectations significantly as the patients believe that restoration of "perfect" vision is now possible.

Code 67041 describes a vitrectomy with removal of a preretinal cellular membrane. It is the least complex code in the family, but still represents a high skill, high intensity intraocular procedure because the area of the retina being treated (the macula) is responsible for central vision. The median work RVU was 23.3 and the 25th percentile 19.75. The median intraservice time was 62.5, shorter than the Harvard time for this procedure. This is typical of most ophthalmology codes (as well as those of other specialties) recently surveyed. Five 99213 post-op visits are required. These visits are at a higher level because all require a dilated retinal exam.

When the consensus panel reviewed the survey results, it felt that the 25th percentile was too high and that an RVU of 19.00 would be appropriate. This results in a code which still has a relatively high IWPUT, typical for ophthalmologic procedures with high intensity but relatively short intraservice times. As we discussed when 66984 (cataract surgery) was reviewed during the Third Five Year review, modern eye surgery is characterized by improvements in technology which significantly reduce the time needed to enter the eye and close the incisions at the end of the procedure. For vitrectomy surgery, surgeons are using sutureless self-sealing incisions which require more technical skill to create, but much less intraservice time overall. This raises the IWPUT significantly.

The RVU of 19.0 compares well with *67218 destruction of localized lesion of the retina, one or more sessions; radiation by implantation of source* which is a RUC reviewed extraocular procedure with less morbidity and chance of complications. For that reason, the specialty recommends **RVU=19.0.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67038

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophth How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 39000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 19,600 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency Percentage - % -

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67042 Tracking Number Specialty Society Recommended RVU: **22.13**
Global Period: 090 RUC Recommended RVU: **22.13**

CPT Descriptor: Vitrectomy, with removal of internal limiting membrane of retina (eg, for repair of macular hole, if performaed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year old male with reduced vision associated with a macular hole

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 29%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review patient record. Review diagnostic testing (fundus photography, extended ophthalmoscopy, fluorescein angiography, and optical coherence tomography). Obtain consent. Write preoperative orders for medications, papillary dilation, and antibiotic prophylaxis. Select appropriate anesthesia. Discuss surgery again with patient and family. Scrub and gown. Perform surgical 'time out' with the OR team. After appropriate anesthesia is administered, the eye is prepped and draped.

Description of Intra-Service Work: The conjunctiva is opened both nasally and temporally. The sclera is entered with a microvitreoretinal (MVR) blade inferotemporally and an infusion cannula is sutured to the sclera. A balanced salt infusion fluid is used to maintain intraocular pressure. The sclera is entered with a MVR blade both superonasally and superotemporally to allow passage of the vitrector and the fiber optic light source. The central vitreous is removed, and vitreous shaved as close as is safe to the vitreous base. The posterior hyaloid is elevated and peeled peripherally. A staining agent is instilled on the surface of the macula. It is irrigated away from the retina and removed from the eye. Then an MVR blade is barbed, and under high magnification of the operating microscope, an edge of the internal limiting membrane is gently elevated. An intraocular micro forceps is introduced through a sclerotomy and used to further elevate and then remove the internal limiting membrane. The peripheral fundus is examined for possible retinal tears. An air-fluid exchange is performed. The air is then replaced with properly diluted gas for tamponade. The sclerotomies are closed if there is a leak. The conjunctiva is closed with interrupted sutures. Antibiotics and cycloplegics are applied to the operated eye.

Description of Post-Service Work: Apply sterile dressing. Instruct recovery room staff on correct positioning of patient. Write post operative orders. Chart progress notes. Discuss surgical procedure and post op instructions with patient and family. Dictate operative note. Communicate with referring physician

Post-service Office work: The patient is typically seen post-operatively at one day, one week, 3 weeks, 5 weeks and 10 weeks.. At each exam the visual acuity is measured, a complete eye exam performed including assessment of the anterior segment, the lens (or implant), the intraocular pressure, and a full dilated fundus exam is performed. The status of the gas bubble is assessed and post operative positioning is altered as a function of the bubble size and value of positioning.. Activity and restrictions are reviewed. Medications are tapered or changed as appropriate. Progress is discussed with referring physician. Progress notes are placed in the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007
Presenter(s):	Stephen Kamenetzky, MD and Trex Topping, MD
Specialty(s):	Ophthalmology

CPT Code:	67042					
Sample Size:	165	**Resp N:**	34	**Response:** 20.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	15.00	**30.00**	40.00	100
Survey RVW:		16.45	22.13	**24.00**	25.00	38.08
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		40.00	60.00	**85.00**	90.00	240.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**115.0**	99211x **0.0** 12x **0.0** 13x **5.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 67042	
	Specialty Recommended
Physician Work RVU:	**22.13**
Pre-Service Evaluation Time:	**10.0**
Pre-Service Positioning Time:	**10.0**
Pre-Service Scrub, Dress, Wait Time:	**15.0**
Intra-Service Time:	**85.00**

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**115.0**	99211x **0.0** 12x **0.0** 13x **5.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67108	090	22.49	**Harvard Time**

CPT Descriptor Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
34802	090	11,345	22.97	**RUC Time**

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 47.0 %

TIME ESTIMATES (Median)	CPT Code: 67042	Key Reference CPT Code: 67108	Source of Time
Median Pre-Service Time	35.00	40.00	
Median Intra-Service Time	85.00	191.00	
Median Immediate Post-service Time	15.00	34.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	25.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	115.0	110.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**269.00**	**438.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.94	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	4.06
Urgency of medical decision making	3.44	3.81
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.81	4.56
Physical effort required	4.31	4.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.63	4.50
Outcome depends on the skill and judgment of physician	4.81	4.75

Estimated risk of malpractice suit with poor outcome	4.31	4.19

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	4.19
Intra-Service intensity/complexity	4.50	4.38
Post-Service intensity/complexity	3.88	4.06

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 67038 was originally submitted by CMS for the Third Five Year review because it had never been RUC valued. Survey data were collected last year. The expert consensus panel of the AAO Health Policy Committee reviewed the data for the service and determined that it would be difficult to value because the code was being used to report several distinct procedures which had evolved over the last decade for the treatment of retinal-vitreal disease. This resulted in confusion regarding the code during the original survey. AAO requested that the RUC refer the code to CPT and the RUC agreed. CPT created a new family of codes and this family is being surveyed. All of the procedures require complex surgical technology to perform. Although in some cases improved technology may result in the work being easier, in this instance the new technology has raised expectations significantly as the patients believe that restoration of "perfect" vision is now possible.

CPT 67042 describes the treatment of a macular hole or chronic macular edema. The code defines a new procedure to treat previously untreatable macular diseases that almost always resulted in permanent loss of central vision. The procedure involves pars plana vitrectomy, removal of the internal limiting membrane of the retina and intraocular tamponade with the installation of a vitreous substitute composed of silicon oil or gas. For these reasons, it is a more sophisticated surgical procedure with additional surgical maneuvers than 67041.

The median survey WRVU was 24.0 and the 25th percentile 22.13. The use of vitreous substitute results in a 30 to 40 per cent incidence of post operative elevated intraocular pressure requiring treatment with topical and systemic medications, and in some instances the in-office removal of fluid from the eye by paracentesis (65805) or by vitreous tap (67015). Neither of these procedures related to the initial surgery, which are performed in the office, would be billable during the global period, but both have significant physician work associated with them. Survey respondents indicated five 99213 visits are required for the typical patient. The respondents indicated that this code was technically more difficult and had higher psychological stress than the reference code which has an WRVU of 22.49, but slightly lower mental effort and judgment regarding medical decision making.

The expert consensus panel of the AAH Health Policy committee reviewed the survey data and recommends the 25th percentile value of **WRVU=22.13.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67038

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophth How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 11000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,785 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67043 Tracking Number Specialty Society Recommended RVU: **22.94**
Global Period: 090 RUC Recommended RVU: **22.94**

CPT Descriptor: Vitrectomy, with removal of subretinal membrane (eg, choraoidal neovascularizaiton), includes if performed, intraocular tamponade (ie, air gas or silicone oil) and laser photocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old patient with reduced vision to 20/100 with subretinal fluid and a choroidal neovascular membrane.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 34%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review patient record. Review diagnostic testing (fundus photography, extended ophthalmoscopy, fluorescein angiography, and optical coherence tomography). Obtain consent. Write preoperative orders for medications, papillary dilation, and antibiotic prophylaxis. Select appropriate anesthesia. Discuss surgery again with patient and family. Scrub and gown. Perform surgical 'time out' with the OR team After appropriate anesthesia is administered, the eye is prepped and draped.

Description of Intra-Service Work: The conjunctiva is opened both nasally and temporally. The sclera is entered with a microvitreoretinal (MVR) blade inferotemporally and an infusion cannula is sutured to the sclera. A balanced salt infusion fluid is used to maintain intraocular pressure. The sclera is entered with a MVR blade both superonasally and superotemporally to allow passage of the vitrector and the fiber optic light source. The central vitreous is removed. The posterior hyaloid is elevated and peeled peripherally and then the vitreous is shaved off as close as is safe to the vitreous base. Under high magnification of the operating microscope, a small gauge cannula is inserted under the retina adjacent to the macula. A minute quantity of fluid is injected into the sub-retinal space to detach the central retina. The infusion bottle height is elevated to tamponade possible massive bleeding. A sub retinal forceps is placed in the eye and through the retinotomy and into the sub retinal space. The forceps blades are placed one above and one under the neovascular membrane. The membrane is removed carefully from the sub retinal space and then from the eye. Air-fluid exchange is performed to reattach the retina. Endolaser photocoagulation may be placed around the posterior retinotomy. The air within the eye is exchanged for a long acting gas for internal tamponade The sclerotomies are closed with sutures. The conjunctiva is closed with interrupted sutures. Antibiotics and cycloplegics are applied to the operated eye.

Description of Post-Service Work: Apply sterile dressing. Instruct recovery room staff on correct positioning of patient. Write post operative orders. Chart progress notes. Discuss surgical procedure and post op instructions with patient and family. Dictate operative note. Communicate with referring physician

Post-service Office work: The patient is typically seen post-operatively at one day, one week, 3 weeks, 5 weeks and 10 weeks. At each exam the visual acuity is measured, a complete eye exam performed including assessment of the anterior segment, the lens (or implant), the intraocular pressure, and a full dilated fundus exam is performed. The status of the gas bubble is assessed and post operative positioning is altered as a function of the bubble size and value of positioning.. Activity and restrictions are reviewed. Medications are tapered or changed as appropriate. Progress is discussed with referring physician.. Progress notes placed in the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007

Presenter(s):	Stephen Kamenetzky, MD and Trex Topping, MD		
Specialty(s):	Opthalmology		
CPT Code:	67043		
Sample Size:	165	**Resp N:** 29	**Response:** 17.5 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	5.00	12.00
Survey RVW:	18.00	22.00	**24.50**	26.50	39.68
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	40.00	65.00	**90.00**	100.00	150.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**138.0**	99211x **0.0** 12x **0.0** 13x **6.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 67043		
		Specialty Recommended
Physician Work RVU:		23.00
Pre-Service Evaluation Time:		10.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		90.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	138.0	99211x 0.0 12x 0.0 13x 6.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67108	090	22.49	Harvard Time

CPT Descriptor Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
34820	090		RUC Time	

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 44.8 %

TIME ESTIMATES (Median)	CPT Code: 67043	Key Reference CPT Code: 67108	Source of Time Harvard Time
Median Pre-Service Time	35.00	40.00	
Median Intra-Service Time	90.00	191.00	
Median Immediate Post-service Time	20.00	34.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	25.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	138.0	110.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**302.00**	**438.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.46	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	4.23
Urgency of medical decision making	4.46	4.31
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.92	4.69
Physical effort required	4.23	4.31
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	4.69
Outcome depends on the skill and judgment of physician	5.00	4.77

Estimated risk of malpractice suit with poor outcome	4.69	4.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.46	4.38
Intra-Service intensity/complexity	4.92	4.54
Post-Service intensity/complexity	4.31	4.23

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 67038 was originally submitted by CMS for the third Five Year review because it had never been RUC valued. Survey data were collected last year. The expert consensus panel of the AAO Health Policy Committee reviewed the data for the service and determined that it would be difficult to value because the code was being used to report several distinct procedures which had evolved over the last decade for the treatment of retinal-vitreal disease. This resulted in confusion regarding the code during the original survey. AAO requested that the RUC refer the code to CPT and the RUC agreed. CPT created a new family of codes and this family is being surveyed. All of the procedures require complex surgical technology to perform. Although in some cases improved technology may result in the work being easier, in this instance the new technology has raised expectations significantly as the patients believe that restoration of "perfect" vision is now possible.

CPT 67043 describes the surgical treatment of subretinal neovascularization with vitrectomy. Currently there is no CPT code that describes this procedure which involves pars plana vitrectomy, incising the retina, creation of a retinal detachment by subretinal injection, subretinal dissection and removal of the neovascular tissue and retinal reattachment with a vitreous substitute. This a low volume procedure expected to account for less than 5 % of vitrectomy procedures previously reported with 67038.

The median WRVU was 24.5 and the 25th percentile 22. The median intraservice time was 90 minutes. The majority of this time is spent inside the eye operating at or under the retinal surface. This procedure ranks in physician work between 67042 and 67113 within this new family of services. The service takes longer than 67042 because subretinal dissection takes longer than preretinal dissection and additional time is necessary to assure subretinal hemostasis after removal of the neovascular tissue. Also, this procedure is typically performed in patients with an attached posterior vitreous which must be dissected from the retinal surface.

The expert consensus panel considered the data and recommends a **WRVU=23.0** which is slightly above the 25th percentile of the survey and just above our proposed value for 67042.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67038

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1300
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 650
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67113 Tracking Number Specialty Society Recommended RVU: **25.00**
Global Period: 090 RUC Recommended RVU: **25.00**

CPT Descriptor: Repair of complex retinal detachment (eg, proliferative vitreoretinopthy, stageC-1 or greater, diabetic traction retinal detachment, retinopathy of prematureity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tampanade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58 year old patient with a total retinal detachment and proliferative vitreoretinopathy consisting of extensive intravitreal membranes.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 29%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The decision that a pars plana vitrectomy is made in order to remove the vitreous. Dissection of the membranes and their attachment is required as well as a relaxing retinopathy with a gas-fluid exchange to allow the retina to reattach. Review patient record. Review diagnostic testing (fundus photography, extended ophthalmoscopy, fluorescein angiography, and optical coherence tomography). Obtain consent. Write preoperative orders for medications, papillary dilation, and antibiotic prophylaxis. Select appropriate anesthesia. Discuss surgery again with patient and family. Scrub and gown. Perform surgical 'time out' with the OR team. After appropriate anesthesia is administered, the eye is prepped and draped.

Description of Intra-Service Work: A complete conjunctival peritomy is performed. Tenon's capsule is peeled back and the rectus muscles are isolated. The sclera is entered with a microvitreoretinal (MVR) blade inferotemporally and an infusion cannula is sutured to the sclera. A balanced salt infusion fluid is used to maintain intraocular pressure. The sclera is entered with a MVR blade both superonasally and superotemporally to allow passage of the vitrector and the fiber optic light source. The central vitreous is removed, and vitreous shaved as close as is safe to the vitreous base. Then a MVR blade is barbed, and under high magnification of the operating microscope, the extensive cellular membranes are meticulously removed from the retinal surface to relieve traction. The peripheral fundus is examined for retinal tears which are marked with endodiathermy. A posterior retinotomy is created with endodiathermy. Fluid is removed from the eye and replaced with gas to create pneumatic retinal reattachment. Extensive endolaser photocoagulation is placed about the peripheral breaks and around the retinotomy. Plugs are placed in the sclerotomy sites.
The surgeon then begins the extraocular portion of the procedure. Mattress sutures are placed in each quadrant to support an encircling buckle of solid silicone which is placed 360 degrees around the equator of the eye. The ends of the buckling material are the connected with a silicone sleeve. The mattress sutures are tied and trimmed after the indentation of the sclera is felt to be appropriate.
The air within the eye is exchanged for a long acting gas. The sclerotomies are closed with sutures, and the conjunctiva is closed with sutures. Antibiotics and cycloplegics are applied to the operated eye.

Description of Post-Service Work: Apply sterile dressing. Instruct recovery room staff on correct positioning of patient. Write post operative orders. Chart progress notes. Discuss surgical procedure and post op instructions with patient and family. Dictate operative note. Communicate with refereeing physician

Post-service Office work: The patient is typically seen post-operatively at one day, one week, 3 weeks, 4 weeks, 8 weeks and 12 weeks. . At each exam the visual acuity is measured, a complete eye exam performed including

assessment of the anterior segment, the lens (or implant), the intraocular pressure, and a full dilated fundus exam is performed. The status of the gas bubble is assessed and post operative positioning is altered as a function of the bubble size and value of positioning. Activity and restrictions are reviewed. Medications are tapered or changed as appropriate. Progress is discussed with referring physician. Progress notes are placed in the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	Stephen Kamenetzky, MD and Trex Topping, MD					
Specialty(s):	Ophthalmology					
CPT Code:	67113					
Sample Size: 138	**Resp N:** 34	**Response:** 24.6 %				
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate						
Survey RVW:		22.49	25.00	**27.00**	30.01	57.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		40.00	120.00	**130.00**	180.00	300.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**161.0**	99211x **0.0** 12x **0.0** 13x **7.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 67113		
		Specialty Recommended
Physician Work RVU:		25.00
Pre-Service Evaluation Time:		10.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		130.00
Immediate Post Service-Time:	20.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	161.0	99211x 0.0 12x 0.0 13x 7.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67108	090	22.49	Harvard Time

CPT Descriptor

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
45110	090	2,796	27.96	RUC Time

CPT Descriptor 1 Proctectomy

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
19367	090	819	25.81	RUC Time

CPT Descriptor 2 Breast reconstruction

Other Reference CPT Code	Global	-	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 82.3 %

TIME ESTIMATES (Median)

	CPT Code: 67113	Key Reference CPT Code: 67108	Source of Time
Median Pre-Service Time	35.00	40.00	
Median Intra-Service Time	130.00	191.00	
Median Immediate Post-service Time	20.00	34.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	25.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	161.0	110.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**365.00**	**438.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.39	4.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.68
Urgency of medical decision making	4.36	4.29

Technical Skill/Physical Effort (Mean)

Technical skill required	4.93	4.50
Physical effort required	4.79	4.32

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.79	4.50
Outcome depends on the skill and judgment of physician	4.93	4.68
Estimated risk of malpractice suit with poor outcome	4.36	4.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.39	4.18
Intra-Service intensity/complexity	4.93	4.36
Post-Service intensity/complexity	4.43	4.04

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 67038 was originally submitted by CMS for the third Five Year review because it had never been RUC valued. Survey data were collected last year. The expert consensus panel of the AAO Health Policy Committee reviewed the data for the service and determined that it would be difficult to value because the code was being used to report several distinct procedures which had evolved over the last decade for the treatment of retinal-vitreal disease. This resulted in confusion regarding the code during the original survey. AAO requested that the RUC refer the code to CPT and the RUC agreed. CPT created a new family of codes and this family is being surveyed. All of the procedures require complex surgical technology to perform. Although in some cases improved technology may result in the work being easier, in this instance the new technology has raised expectations significantly as the patients believe that restoration of "perfect" vision is now possible.

CPT 67113 describes the repair of a complex retinal detachment described in detail in the new descriptor which includes vitrectomy as part of the procedure. Currently no single CPT procedure accurately describes the surgical repair of complex retinal detachment using this technique, so surgeons used 67038 and 67108.CMS has expressed concern that the combination of the retinal detachment repair and vitrectomy codes resulted, even with a multiple procedure modifier, in a total WRVU that was overvalued.

The service represented by this code is the most complex of the four codes in the series of vitrectomy procedures. In fact, it is likely the most complex ocular surgical procedure performed currently. This surgery is performed only by fellowship trained retina surgeons. CPT 67113 combines pars plana vitrectomy with a number of other surgical procedures that may include scleral buckling, dissection of periretinal scar tissue, retinal repositioning, retinopexy with laser or cryopexy, cataract extraction and installation of a vitreous substitute, either an expansible gas or silicon oil.

The survey found a median WRVU of 27.00 and a 25th percentile of 25.00. The median intraservice time was 130 minutes. All of the intensity complexity measures were higher than the reference code, the majority significantly so. The need for retinal tamponade with a vitreous substitute results in a 30% incidence of elevated intraocular pressure requiring treatment with topical and systemic medications or in some cases the in-office removal of fluid from the eye by paracentesis (65805) or by vitreous tap (67015). Neither of these procedures, would be billable during the global period, but both have significant physician work associated with them. Based on survey responses, seven 99213 post-operative visits are required.

This service is much more complex than the reference code 67108 chosen by most respondents which has a value of 22.49. As we discussed when 66984 (cataract surgery) was submitted to the Five Year review, modern eye surgery is

characterized by improvements in technology which significantly reduce the time needed to enter the eye and close the incisions at the end of the procedure. For vitrectomy, physician are using unsutured, self-sealing incisions which require more technical skill to create but much less intraservice time overall. **The consensus committee reviewed the survey findings and recommends the 25th percentile of 25.00 RVUs.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67038/67108

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophth How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 11000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,785 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

		67041		67042		67043		67113	
	CMS Code	Vitrectomy w/ removal of preretinal membrane (e.g. macular pucker)		removal of internal limiting membrane (e.g. macular hole repair)		removal of subretinal membrane (e.g. choroidal neovascularizatio		Repair of complex retinal detachement (e.g. PVR)	
LOCATION		N/A In Office	Out Office	N/A In Office	Out Office	N/A In Office	Out Office	N/A In Office	Out Office
GLOBAL PERIOD		90	90	90	90	90	90	90	90
TOTAL CLINICAL LABOR TIME	L037D	0	246	0	246	0	282	0	318
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms	L037D		5		5		5		5
Coordinate pre-surgery services	L037D		20		20		20		20
Schedule space & equipment in facility	L037D		8		8		8		8
Office visit before surgery/procedure: Review test and exam results	L037D		0		0		0		0
Provide pre-service education/obtain consent	L037D		20		20		20		20
Follow-up phone calls & prescriptions	L037D		7		7		7		7
Other Clinical Activity (please specify)	L037D		0		0		0		0
End:When patient enters office for surgery/procedure									
TOTAL Pre-Service CLINICAL LABOR TIME	L037D	0	60	0	60	0	60	0	60
SERVICE PERIOD									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts									
Greet patient and provide gowning									
Obtain vital signs									
Provide pre-service education/obtain consent									
Prepare room, equipment,supplies									
Prepare and position patient/ monitor patient/ set up IV									
Sedate/apply anesthesia									
Intra-service									
Assist physician in performing procedure									
Post-Service									
Monitor pt. following service/check tubes, monitors, drains									
Clean room/equipment by physician staff									
Complete diagnostic forms, lab & X-ray requisitions									
Review/read X-ray, lab, and pathology reports									
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions									
Other Clinical Activity (please specify)									
End: Patient leaves office									
Total Day-of-procedure time		0	6	0	6	0	6	0	6
POST-SERVICE Period									

		67041		67042		67043		67113	
	CMS Code	Vitrectomy w/ removal of preretinal membrane (e.g. macular pucker)		removal of internal limiting membrane (e.g. macular hole repair)		removal of subretinal membrane (e.g. choroidal neovascularizatio		Repair of complex retinal detachement (e.g. PVR)	
LOCATION		N/A In Office	Out Office	N/A In Office	Out Office	N/A In Office	Out Office	N/A In Office	Out Office
GLOBAL PERIOD		90	90	90	90	90	90	90	90
Start: Patient leaves office									
Conduct phone calls/call in prescriptions									
Office visits:									
List Number and Level of Office Visits									
99211 16 minutes									
99212 27 minutes									
99213 36 minutes	L037D		**5**		**5**		**6**		**7**
99214 53 minutes									
99215 63 minutes									
Other									
Total Office Visit Time		0	180	0	180	0	216	0	252
Conduct phone calls between office visits		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other Activity (please specify)		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
End: with last office visit before end of global period									
MEDICAL SUPPLIES									
Ophthalmology visit package	SA082		5		5		6		7
Equipment									
Exam Lane	E71109		**5**		**5**		**6**		**7**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Retinopathy Treatment

CPT code 67228, *Treatment of extensive or progressive retinopathy; (eg, diabetic retinopathy), photocoagulation; single session*, was originally referred to the third Five-Year Review by CMS. At that time, the RUC referred the code to the CPT Editorial Panel for revisions because there were difficulties in reviewing the physician work due to a lack of uniformity between the vignette and the descriptor. It was unclear whether or not the work being described was for a single session or the typical number of treatments during the global period (between 2 and 3). The Panel removed the "one or more sessions" language, replaced it with "single session," and the specialty society recommended that the code be changed from a 90 day global to a 10 day global period. CMS did not approve a change in the global period. This action created difficulty in assessing whether the work within the code should include a single session or the typical multiple sessions. In addition to these changes, the Panel created one new code in the family, 67229, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc); preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions*, to describe retinopathy treatment in pre-term infants performed in the first year of life.

The specialty society noted that the changes to the global period were assumed within the vignette and description for the edits approved by the CPT Editorial Panel. However, they were not approved by CMS and the service remains a 90 global and accounts for only one procedure. The procedure is typically performed between two and three times, as reflected in the specialty society survey, with an average of 2.4. The survey respondents assumed the inclusion of multiple treatments when the code was surveyed and the recommended values are based on this assumption.

The RUC recommends that the CPT Editorial Panel remove "single session" from the CPT descriptor for code 67228. [Staff note: The CPT Editorial Panel accepted this recommendation at its February 2007 meeting.]

The RUC discussed the survey data for 67228 in comparison with the reference service code, 67145, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)*,

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(work RVU = 6.17, pre-service time = 24, intra-service time = 25, post-service time = 11). The reference service is considerably lower in nearly every measure of intensity and complexity for the pre-, intra-, and post-service periods. The surveyed code requires greater mental effort, complexity, technical skill, physical effort, and risk than the reference service. The reference service which has a work RVU of 6.17, when multiplied by 2.4 is 14.81, which is very similar to the current work RVU of 13.76. Based on the similarity to the reference service and the average of 2.4 treatments within the global period, the RUC recommends maintaining the current work RVU of 13.76, which includes the updates to the E/M services inherent in the global period of the procedure. Further the RUC recommends adjusting the mean pre-, intra-, and post-service physician times by 2.4 times the median survey times to appropriately account for the performing the procedure 2.4 times. **The RUC recommends a work RVU of 13.67, pre-service time of 48 minutes, intra-service time of 60 minutes, and post-service time of 12 minutes for 67228.**

The RUC considered the specialty society survey data for code 67229, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc); preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions* and agreed that the median work RVU was appropriate when compared to the reference service code 67145, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)*, (work RVU = 6.17). The RUC agreed that the work involved in code 67229 is far more intense and complex than the reference service. The intra-service time is exactly three times that of 67145, and the RUC concurred that the median work RVU of 16.00 is appropriate as it is slightly less than three times the reference service work RVU of 6.17. The RUC also discussed the service in comparison with 67107, *Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid* (work RVU = 16.35), which was the second most commonly selected reference service from the survey results. The intra-service time is slightly greater in the reference service than the surveyed code, 107 minutes and 75 minutes, respectively. However, the surveyed code is more extensive and carries a greater risk of unfavorable visual outcome. The RUC considered one additional reference service, code 65782, Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft) (work RVU = 15.16), but has a far more similar intraservice time, 83 minutes. **The RUC recommends a work RVU of 16.00, pre-service time of 45 minutes, intra-service time of 75 minutes, and post-service time of 17.50 minutes for code 67229.**

Practice Expense

The RUC accepted the practice expense inputs as amended by the PERC and as adjusted for the change in intra-service time for 67228.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
e▲67227		Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions~~;~~, cyrotherapy, diathermy	090	7.38 (No Change)
▲67228	J1	Treatment of extensive or progressive retinopathy; (eg, diabetic retinopathy), photocoagulation ~~(laser or xenon arc), single session~~	090	13.67 (No Change)
●67229	J2	preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions (For bilateral procedure, use modifier 50)	090	16.00

1439

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67228 Tracking Number Specialty Society Recommended RVU: **13.67**
Global Period: 090 RUC Recommended RVU: **13.67**

CPT Descriptor: Treatment of extensive or progressive retinopathy; (eg, diabetic retinopathy), photocoagulation, single session

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47 year old male with a 15-year history of insulin dependent diabetes mellitus with proliferative diabetic retinopathy who meets high risk characteristics

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient has previously been evaluated and scheduled for therapy. The medical record is reviewed. An interim history is obtained. Diagnostic testing (e.g. fundus photography, fluorescein angiography and possible optical coherence tomography) is reviewed. A full discussion of risks and benefits of the procedure is carried out with the patient. Consent is obtained.

Description of Intra-Service Work: The visual acuity is measured and the pupil is dilated. The fundus is examined to ensure that laser therapy is still appropriate (as opposed to vitreous surgery). A topical anesthetic is applied to the cornea. Laser photocoagulation is administered by either one of two techniques: 1. slit lamp delivery system or 2. indirect ophthalmoscopic delivery system. With the slit lamp laser system a fundus contact lens is applied to the globe using a liquid methylcellulose cushion. Laser ablation is applied to the mid-peripheral and peripheral retina. With indirect ophthalmoscopic delivery, an anesthetic is applied topically to the cornea. The laser ablation is applied to the mid-peripheral and peripheral retina

Description of Post-Service Work: The eye is irrigated. The patient is apprised of the progress of the treatment, any complications, and is told of what to expect post-operatively. Post operative orders are written. The operative note is prepared. Follow up appointment is scheduled. Referring physician is notified of treatment

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Stephen Kamenetzky, MD and Trex Topping, MD				
Specialty(s):	Ophthalmology				
CPT Code:	67228				
Sample Size: 154	**Resp N:** 30	**Response:** 19.4 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	10.00	40.00	**67.50**	118.75	1000.00
Survey RVW:	5.50	7.69	**11.00**	16.00	23.30
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**5.0**		

CPT Code: 67228

Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		10.00	20.00	**25.00**	43.75	90.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**19.0**	99238x **0.50**	99239x **0.00**			
Office time/visit(s):	**69.0**	99211x **0.0**	12x **0.0**	13x **3.0**	14x **0.0**	15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0**	55x **0.0**	56x **0.0**	57x **0.0**	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 67228	
	Specialty Recommended
Physician Work RVU:	**13.67**
Pre-Service Evaluation Time:	**24.0**
Pre-Service Positioning Time:	**12.0**
Pre-Service Scrub, Dress, Wait Time:	**12.0**
Intra-Service Time:	**60.00**

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**19.0**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**69.0**	99211x **0.0** 12x **0.0** 13x **3.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67145	090	6.17	**Harvard Time**

CPT Descriptor Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)	CPT Code: 67228	Key Reference CPT Code: 67145	Source of Time
Median Pre-Service Time	48.00	24.00	
Median Intra-Service Time	60.00	25.00	
Median Immediate Post-service Time	12.00	11.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	69.0	58.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**208.00**	**118.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.40
Urgency of medical decision making	3.90	4.10
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	4.10
Physical effort required	3.90	3.60
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	4.00
Outcome depends on the skill and judgment of physician	4.00	4.20

Estimated risk of malpractice suit with poor outcome	3.80	3.70

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.40
Intra-Service intensity/complexity	3.70	3.40
Post-Service intensity/complexity	3.30	3.20

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was originally submitted by CMS for the Five Year Review because if had never previously been reviewed. When the code was surveyed, it was felt that difficulties with the vignette and the CPT descriptor language prevented an accurate assessment of the physician work because it was not clear whether the work being described was for a single session or the usual number of treatments during the global period (2 to3). When the problem and survey findings were presented to the RUC, there was agreement that the code should be referred to CPT for refinement in the descriptor to clarify the issue. At CPT, we recommended changing the code to a 10-day global, describing each individual treatment session and removing "one or more sessions" from the CPT descriptor. That change was approved by CPT. However CMS did not agree to a 10-day global for this procedure and insisted that the survey be performed for a 90-day global period. However "one or more sessions" was appropriately deleted from the descriptor in the new code.

Unfortunately this decision by CMS recreated the initial problem that the referral to CPT had been designed to alleviate: lack of clarity as to whether the survey respondents were evaluating the work of the single session or the entire course of treatment. Not surprisingly, the new survey generated the same ambiguous responses as the prior one. This confusion is clearly demonstrated by looking at the intraservice time data from the survey. It is impossible to complete 2 to 3 treatment sessions in the median time of 25 minutes. In fact, that time is closer to the typical intraservice time for a single session. Therefore, the consensus panel of the AAO believes most respondents indicated service times for a single session. This is supported by the fact that the most common reference code chosen (67145) is typically administered in a single session.

Given the issues with the survey using a 90-day global, the consensus panel discussed the issue of how to better determine the number of treatments during the global period with RUC staff and they allowed us to ask the respondents an additional question via the survey:

> "The Academy is surveying this revised CPT code for panretinal photocoagulation with a format we are required to use for RUC Surveys.
>
> The form is designed for procedures assigned a 90-day global period by CMS (Medicare). However, the new descriptor was intended to represent the services provided within a 10-day global period.
>
> The typical treatment of this type of patient often requires more than one treatment session. In order for us to

provide information to CMS and the AMA Relative Value Update Committee (RUC) on the best timeframe and valuation for this procedure it is important for the Academy to establish the number of treatment sessions for proliferative diabetic retinopathy (PDR) as described in the patient vignette that would be provided in a 90-day time period. Please indicate here the number of treatments that would be required for one eye with PDR in the typical patient within a 90-day time period: _____."

The respondents indicated that on average about 2.4 treatments were required within 90 days. This is consistent with two NIH clinical trials of the treatment of proliferative diabetic retinopathy as well as the current standard of practice which indicate that the treatments should be performed in a minimum of 2 sessions, but more commonly in 3 sessions (see references below).

The reference code chosen has a RVU of 5.36, and multiplying that by 2.4 gives a calculated RVU of 12.86, very close to the current value (12.72 RVU). In addition, those surveyed felt that the new code had higher intensity and complexity than the reference code. The AAO expert consensus panel composed of members of the Health Policy Committee reviewed these findings and feels that there is no compelling evidence to support the conclusion that the code is overvalued at the present time. In addition, there is no clear method to better determine a value given the issues discussed previously. **The committee therefore recommends that the present value (RVU=12.72) be reaffirmed.** This value is consistent with other RUC evaluated codes. For instance *49085 Removal of peritoneal foreign body from peritoneal cavity* has an RVU =12.12, and an intraservice time of 60 minutes. *43605 biopsy of stomach by laparotomy* has a similar intraservice time with an RVU=11.96.

References:

Diabetic Retinopathy Study Research Group. Photocoagulation treatment of proliferative diabetic retinopathy: clinical application of the DRS findings. DRS report No. 8. *Ophthalmology* 1981; 88:583-600.

Early Treatment Diabetic Retinopathy Study Research Group. Photocoagulation for diabetic macular edema. ETDRS report No 1. *Arch Ophthalmol* 1985;103:1796-1806.

Vander JF, Duker JS, Benson WE, et al. Longterm stability and visual outcome after favorable initial response of proliferative diabetic retinopathy to panretinal photocoagulation. *Ophthalmology* 1991:98:1575-1579.

Diabetes and Ocular Disease. Ophthalmology Monograph 14. Flynn HW and Smiddy WE, eds. The Foundation of the American Academy of Ophthalmology. San Francisco, 2000, pages 138-139.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67228

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophth How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 220000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 110,068 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

Attestation Statement

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:67229 Tracking Number Specialty Society Recommended RVU: **16.00**
Global Period: 090 RUC Recommended RVU: **16.00**

CPT Descriptor: Treatment of extensive or progressive retinopathy; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10 week old infant born at 25 weeks post-menstrual age with threshold retinopathy of prematurity.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 33%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Once the decision for treatment is made consultation is completed with the consulting neonatologist as to the advisability of surgery, the location of the surgery (OR versus NICU), type of anesthetic to be used (conscious sedation versus general aneshtesia) and airway management. The family is contacted and the nature of the proposed surgery including the risks and liklihood of benefit discussed. Orders for pupillary dilation are placed in the record. The family is counseled in the waiting area. An interval history and ophthalmological exam are documented.

Description of Intra-Service Work: The correct surgical eye is confirmed. Topical anesthesia is adminstered along with supplemental mydriatic drops as needed. A eyelid speculum is placed. The eye is positioned with scleral depression. The regions of normal vascularization and absent vascularization are recorded. Retinal ablation is performed with the application of laser burns to the avascular retina with an indirect ophthalmoscopic laser delivery system. Initial applications are titrated to cause an immediate cream colored response in the treated retina. The entire avascular retina is treated with near confluent burns, usually taking 1000 to 1500 applications. Care is taken to avoid striking the iris and maintaining laser focus on the retina to avoid damage to the crystalline lens.

Description of Post-Service Work: Following surgery the op note is dictated. Post op orders are written including topical steroids and antibiotics and arrangements made for follow up in 3 to 7 days. The outcome of the procedure discussed with the neonatology team. The course of the procedure and expectations for the next few weeks are reviewed with the family

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007					
Presenter(s):	George Williams, MD and Stephen Kamenetzky, MD					
Specialty(s):	Ophthalmology					
CPT Code:	67229					
Sample Size:	119	**Resp N:** 24	**Response:** 20.1 %			
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**10.00**	13.50	35.00

CPT Code: 67229

Survey RVW:		6.17	12.58	**16.00**	21.03	45.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	60.00	**75.00**	105.00	240.00
Immediate Post Service-Time:	**17.50**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**40.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**38.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**138.0**	99211x **0.0** 12x **0.0** 13x **6.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 67229		
		Specialty Recommended
Physician Work RVU:		16.00
Pre-Service Evaluation Time:		15.0
Pre-Service Positioning Time:		15.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		75.00
Immediate Post Service-Time:	17.50	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	40.0	99231x 0.0 99232x 1.0 99233x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0 99239x 0.0
Office time/visit(s):	138.0	99211x 0.0 12x 0.0 13x 6.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67145	090	6.17	Harvard Time

CPT Descriptor Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
58150	090	24,214	15.2	RUC Time

CPT Descriptor 1 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
65750	090	1,056	14.98	RUC Time

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	CPT Code: 67229	Key Reference CPT Code: 67145	Source of Time Harvard Time
Median Pre-Service Time	45.00	24.00	
Median Intra-Service Time	75.00	25.00	
Median Immediate Post-service Time	17.50	11.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	138.0	58.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**353.50**	**118.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.00
Urgency of medical decision making	4.57	3.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.43	3.86
Physical effort required	4.71	3.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.57	3.00
Outcome depends on the skill and judgment of physician	4.71	3.86

Estimated risk of malpractice suit with poor outcome	4.86	3.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.14	3.00
Intra-Service intensity/complexity	4.43	3.43
Post-Service intensity/complexity	4.14	3.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The CPT Editorial Panel added a new CPT code for retinopathy of prematurity treatment. The new code identifies services provided to a "preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions." These patients had previously been reported with 67228 (which is part of the Third Five-year Review), but it was felt that a separate code for this very small subset of patients was necessary to capture the additional work and risks inherent in dealing with a high risk pediatric population.

The service is performed in the hospital setting on very low birth weight infants at an average post-menstrual age of 37.5 weeks. About 10% of eyes require a repeat treatment, usually in 10-21 days. These are high-risk patients with a 20% likelihood of permanent severe visual impairment and 30% moderate impairment in spite of treatment. They usually have a myriad of associated medical conditions which substantially increases the complexity of the treatment. The professional liability risk is also significantly higher than in the adult population because the risk of blindness is much higher.

The survey revealed that the work involved for 67229 was substantially higher in terms of mental effort, technical skill and psychological stress than the most commonly chosen reference code, 67145. This is not surprising as the treatment (67145) is far less extensive and carries substantially lower risk of an unfavorable visual outcome. In addition far more parent education is necessary prior to the procedure to reduce the risk of failure to complete follow-up after surgery. It is likely this reference code was chosen since it is one of the few retinal laser procedures on the reference list. The more similar laser procedure 67228 was being reconsidered as part of the Five Year Review so it could not be utilized. The next most commonly chosen reference procedures was 67107 with a WRVU of 14.82

The 25th percentile in the survey was 10.43 RVU and the median 15.00 RVU. The current value is 12.72 RVU. The median pre-service, intra-service and post-service times were 45, 75, and 15 minutes. Post-operative visits occur weekly in the first four weeks. The first of these is typically performed as an inpatient (usually 99232), a discharge day visit, and subsequent visits as an outpatient (99213). During month two the examinations are biweekly and during month three a single visit is required. Each of these visits requires reexamination of the anterior segment for evidence of iris neovascularization, cataract development and pupillary dilation for peripheral retinal examination with scleral depression to determine the progression or involution of the retinal disease. In addition many children need coordination of care with community-based vision support programs.

The intraservice time and the proposed work value are similar to another recently RUC reviewed code, 65782 - Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft). 65782 has an RVU of 14.98 with slightly longer preservice time and similar intraservice and post service times. The number of post operative follow up visits is higher, but they are 99212 rather than 99213.

The survey respondents suggested a median RVU of 16.0. While we are reluctant to suggest a median value under ordinary circumstances, the consensus panel met by conference call and agreed to recommend WRVU=16.0 to account for the necessary coordination of care, increased number of post-operative visits, the intensity of the intraservice work when compared to the adult population undergoing laser surgery of the retina, and additional technical skill required to treat premature infants.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67228

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Opthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Frequency Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

	A	B	C	D	E	F	G
1	RUC Recommendation						
2				67228		67229	
3	Meeting Date: February 2007 Note: 67228 is valued as a single session. CMS will calculate it by the surveyed treatments of 2.4			Pan-retinal photocoagulation for extensive retinopathy(e.g.diabetic)one or more sessions		Photocoagulation or cryotherapy, retinopathy (e.g ROP) preterm infant (<37wks gest age)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	N/A	Facility
5	GLOBAL PERIOD			90	90		90
6	TOTAL CLINICAL LABOR TIME			176.0	168.0	0.0	246.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			35.0	60.0	0.0	30.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			33.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			108.0	108.0	0.0	216.0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms			5	5		5
13	Coordinate pre-surgery services			10	20		10
14	Schedule space and equipment in facility			0	8		5
15	Provide pre-service education/obtain consent			10	20		10
16	Follow-up phone calls & prescriptions			10	7		0
17	Other Clinical Activity (please specify)						
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure						
21	Pre-service services						
22	Review charts						
23	Greet patient and provide gowning			3			
24	Obtain vital signs			3			
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	Intra-service						
31	Assist physician in performing procedure			25			
32	Post-Service						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff			2			
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 --12 minutes 99239 -15 minutes						
41	Other Clinical Activity (please specify)						
42	End: Patient leaves office						
43	POST-SERVICE Period						
44	Start: Patient leaves office/facility						
45	Conduct phone calls/call in prescriptions						
46	*Office visits:*						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes	L038A	36	3	3		6
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54							
55	*Total Office Visit Time*			108	108	0	216
56	Other Activity (please specify)						
57	End: with last office visit before end of global period						
58	MEDICAL SUPPLIES	CMS Code	Unit				
59	Ophthalmology visit pack (w/ dilation)	SA082	item	4	3		6
60	Xylocaine 2% w/ epinephrine	SH049	ml	5			
61	syringe, plastic, 3cc	SC055	item	3			
62	needle, retrobulbar, 25g	SC081	item	3			
63	goniosol	SH037	ml	3			
64	Equipment	CMS Code					
65	Dedicated slit lamp for argon laser	E71001		4			
66	Argon-krypton laser	E72002		4			
67	Goldmann 3-mirror lens or equivalent			4			
68	Exam Lane	E71109		4	3		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Nasolacrimal Duct Balloon Catheter Dilation

The CPT Editorial Panel created one new code to describe the distinct procedure of probing the nasolacrimal duct with transluminal balloon catheter dilation when other probing methods have failed.

The RUC reviewed the survey data for code 68816 *Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation* compared to the key reference code 68811 *Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* (Work RVU=2.39). The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 3.00 was appropriate in comparison to the reference service and this family of codes. The surveyed code, 68816, intra-service time of 25 minutes was comparable to that of the key reference service with 23 minutes physician intra-service time. The RUC reviewed the surveyed pre-service and immediate post-service times and determined that 30 minutes pre-service and 15 minutes immediate post-service times are similar to the reference code 68811 (30 minutes pre-service and 20 minutes post-service) and are appropriate. The specialty society indicated that CPT code 68816 is more difficult technically than 68811 due to the need to position, identify and follow the inflation-deflation balloon protocol, but is not as technically difficult as probing followed by stent placement, code 68815 *Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent* (Work RVU=3.24, and 40 minutes intra-service time). Additionally, the mental effort and judgment, technical skill, physical effort and stress associated to perform 68816 were all higher than the key reference service 68811, supporting a slightly higher work RVU. The RUC recommends two level 99212 post-operative visits and a half-day discharge day are required, which is consistent with other codes in this family.

The RUC recommends the survey 25th percentile work RVU of 3.00 for code 68816.

Practice Expense
The RUC reviewed the accepted the direct practice expense inputs for 68816 with the 100 percent assist physician time as indicated.

New Technology
The RUC recommends that CPT code 68816 be placed on the new technology list.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
68810		Probing of nasolacrimal duct, with or without irrigation;	010	2.63 (No Change)
68811		requiring general anesthesia	010	2.39 (No Change)
68815		with insertion of tube or stent	010	3.24 (No Change)
●68816	QQ1	with transluminal balloon catheter dilation (Do not report code 68816 in conjunction with 68811, 68815) (For bilateral procedure, report 68816 with modifier 50)	010	3.00

1458

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:68816 Tracking Number QQ1 Specialty Society Recommended RVU: **3.00**
Global Period: 010 RUC Recommended RVU: **3.00**

CPT Descriptor: Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-month old patient has the diagnosis of nasolacrimal duct obstruction which has been unresolved for six months.

Percentage of Survey Respondents who found Vignette to be Typical: 40%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 12%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient history, physical exam, and any required preoperative tests are reviewed. The parents and the patient if age appropriate are counseled in the preoperative area. Active dacryocystitis is ruled out. The preoperative interval history, note and exam are documented in the patient record. The surgeon answers any additional questions. Then patient co-morbidities are discussed with anesthesia. The operative consent form is reviewed and the operative side is confirmed and marked. The surgeon confirms that the correct diameter balloon catheter and inflation device are available in the operating suite.

Description of Intra-Service Work: The inferior meatus is packed with cottonoids soaked in phenylephrine. The puncta are dilated. The nasolacrimal system is probed and the presence of the probe in the nose is confirmed by visualizing the probe in the nasopharynx or touching the probe with a second probe. Irrigating saline tinted with fluorescein may be irrigated and recovered from in the nose. The probe is removed. A deflated balloon catheter is passed through the superior punctum, canalicular system and into the nasolacrimal duct to the nasal floor. Presence of the balloon catheter in the nose is confirmed. An inflation device is filled with sterile water or saline, connected to the balloon catheter, and the balloon is inflated for 90 seconds. The balloon is then deflated for 60 seconds. The inflation procedure is repeated a second time for 60 seconds, again the balloon is deflated. The balloon is retracted 5 mm, thereby positioned within the lacrimal sac and the proximal nasolacrimal duct. The balloon is inflated and deflated again for two cycles using the method described above. The balloon is deflated fully. The catheter is then rotated clockwise to minimize the profile of the deflated balloon, and withdrawn from the lacrimal system.

Description of Post-Service Work: Post op instructions are communicated to the family. A follow up appointment is scheduled. An operative report is dictated and communication with other health professionals is provided as needed. Post-operative evaluations are typically once or twice during the first ten days after procedure (e.g., one day and one week postop). If symptoms persist, alteration of the medical regimen and/or plans for additional procedures are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Stephen Kamenetzky, MD and Neal Freeman, MD		
Specialty(s):	American Academy of Ophthalmology and American Society of Ophthalmic Plastic and Reconstructive Surgery		
CPT Code:	68816		
Sample Size:	175	**Resp N:** 33	**Response:** 18.8 %
Sample Type:	Random		

CPT Code: 68816

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	3.00	**10.00**	22.00	100.00
Survey RVW:		1.50	3.00	**3.50**	4.30	13.93
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		10.00	15.00	**25.00**	30.00	75.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**19.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**32.0**	99211x **0.0** 12x **2.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 68816		
		Specialty Recommended
Physician Work RVU:		3.00
Pre-Service Evaluation Time:		10.0
Pre-Service Positioning Time:		5.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		25.00
Immediate Post Service-Time:	15.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	19.0	99238x 0.5 99239x 0.0
Office time/visit(s):	32.0	99211x 0.0 12x 2.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
68811	010	2.39	RUC Time

CPT Descriptor Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
11623	010	24,713	3.06	RUC Time

CPT Descriptor 1 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 69.6 %

TIME ESTIMATES (Median)

	CPT Code: 68816	Key Reference CPT Code: 68811	Source of Time RUC Time
Median Pre-Service Time	30.00	30.00	
Median Intra-Service Time	25.00	23.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	32.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**121.00**	**105.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.87	2.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.52	2.13
Urgency of medical decision making	2.30	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.35	2.48
Physical effort required	2.91	2.26

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.65	2.04
Outcome depends on the skill and judgment of physician	3.22	2.57

Estimated risk of malpractice suit with poor outcome	2.22	2.04

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.83	2.22
Intra-Service intensity/complexity	3.22	2.09
Post-Service intensity/complexity	2.43	2.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

AAO is presenting data for valuation of a code that resulted from a submission by industry to the CPT Editorial Panel. This code identifies a new technique for treating nasolacrimal duct obstruction. The procedure involves inflating a balloon that has been placed in the lacrimal drainage system, thus dilating the outflow passage and relieving the obstruction. The typical patient is a child, but it will also be used in adults with the object in both cases to avoid having to perform more extensive nasolacrimal system surgery.

A significant number of the respondents indicated that they felt that the vignette was not typical. The reasons varied, but for some oculoplastic specialists it was that they used it primarily in adults. Some pediatric ophthalmologists felt that the vignette should have mentioned that a standard probing had failed before using this technique. Though that may be the case for these respondents, there are at least three recent studies (including one sponsored by the National Eye Institute of NIH) utilizing this service as primary treatment. We found no systematic difference in work value suggested by those respondents that felt that the vignette was typical and those that did not, and for that reason feel that the survey results are valid. The consensus panel did not feel there was significant difference in physician work between these three clinical settings (adult, primary treatment in a child, secondary treatment in a child), but believe that this procedure is substantially more often provided to young children than any other age group.

The AAO surveyed 175 ophthalmologists and got 33 responses. The 25th percentile work value was 3.00 with a median intraservice time of 25 minutes. Survey respondents indicated that the mental effort and judgment, technical skill, physical effort and stress were all higher than the most frequently chosen reference code 68811. Two level 99212 post op visits are required which is consistent with the other codes in the family, 68811 and 68815.

When the surveys were reviewed by the AAO consensus panel, it was felt that this work value fits well within the family of lacrimal codes and also with other RUC-valued 10-day global codes. A WRVU of 3.00 falls between the value of 68811 which has a WRVU of 2.39 and an IST of 23 minutes and 68815 with a WRVU of 3.24 and an IST of 40 minutes. The new code is more difficult technically than the probing (68811) due to the need to position, identify, and follow the inflation-deflation balloon protocol, but not as technically difficult as probing followed by stent placement (68815) which involves placement of a device to keep the system open.

In addition the value is consistent with other RUC valued codes with 10-day global periods. For example 11623 (a MPC-A code) *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* has an RVU of 3.02 with an IST of 30 minutes. Code 37609 *Ligation or biopsy, temporal artery* also has a

value of 3.02 with an IST of 30 minutes. There are other examples as well with WRVUs between 2.88 and 3.22 with similar ISTs.

After review of all of the data, the AAO recommends a WRVU of 3.00, the 25th percentile of the survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 68815

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage 0.00 %
Specialty	Frequency	Percentage %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

	A	B	C	D	E
1				68816	
2	Meeting date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Probing of nasolacrimal duct w/ or w/o irrigation; w transluminal balloon catheter dilation	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
4	GLOBAL PERIOD			10	10
5	TOTAL CLINICAL LABOR TIME	L038A	COMT/COT/RN/CST	118.0	90.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L038A	COMT/COT/RN/CST	18.0	30.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L038A	COMT/COT/RN/CST	46.0	6.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L038A	COMT/COT/RN/CST	54.0	54.0
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST	5	5
12	Coordinate pre-surgery services			3	10
13	Schedule space and equipment in facility				5
14	Provide pre-service education/obtain consent			7	7
15	Follow-up phone calls & prescriptions			3	3
16	Other Clinical Activity (please specify)				
17	**End:When patient enters office/facility for surgery/procedure**				
18	SERVICE PERIOD				
19	**Start: When patient enters office/facility for surgery/procedure**				
20	**Pre-service services**				
21	Review charts				
22	Greet patient and provide gowning			3	
23	Obtain vital signs			3	
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies			2	
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV				
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure - 100%			25	
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff			3	
34	Clean Scope				
35	Clean Surgical Instrument Package			10	
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Discharge day management 99238 --12 minutes				6
40	Other Clinical Activity (please specify)				
41	**End: Patient leaves office**				
42	POST-SERVICE Period				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
45	*Office visits*				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27	2	2
49	99213 36 minutes		36		
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53					
54	*Total Office Visit Time*			54	54
55	Other Activity (please specify)				
56	**End: with last office visit before end of global period**				

	A	B	C	D	E
1				68816	
2	Meeting date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Probing of nasolacrimal duct w/ or w/o irrigation; w transluminal balloon catheter dilation	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility
57	MEDICAL SUPPLIES	CMS Code	Unit		
58	pack, ophthalmology visit (no dilation)	SA050		3	2
59	pack, cleaning surgical instruments	SA043		1	
60	gloves, sterile	SB024	pair	2	
61	drape, sterile for Mayo stand	SB012		1	
62	Betadine swabstick	SJ043	3 pack	1	
63	syringe, 5 cc	SC057		1	
64	needle, 18-27ga	SC029		1	
65	needle, 30ga	SC031		1	
66	lidocaine 2% w/ epinephrine,	SH049	cc	5	
67	phenylephrine 2.5%	SH056	cc	1	
68	Suction catheter	SD031		1	
69	applicator, cotton tipoped, sterile 6"	SG081		20	
70	Balanced salt solution (BSS)	SH078	15cc	1	
71	Erythromycin ophthalmic ointment	SH032	3.5gm	1	
72	catheter, balloon, lacrimal			1	
73	Equipment	CMS Code	Util %		
74	screening lane	E71111		2	2
75	basic surgical pack	EQ137		1	
76	surgical loupes	E30018		1	1
77	surgical light	E30009		1	
78	Mayo stand	EF015			
79	power table	E11003		1	
80	Suction machine (GOMCO)	E30001		1	
81	Light, fiberoptic headlight w/ source	E13122		1	
82	Pulse Oximeter	E55003		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Cardiac MRI

Improvement in spatial and temporal resolution has expanded the applications of cardiac MRI from predominantly an anatomic test to one that performs accurate physiologic evaluations. Because of this improvement, cardiac MRI is unlike traditional MRI which relies solely on static images to obtain clinical diagnoses. This expansion in technology has led to a test that is now technically more complex to perform and includes more physician work to adjust imaging planes, decide on sequences, evaluate the images, and assimilate the data into an effective treatment plan. Because of the clinical expansion and additional work, new CPT codes and descriptors were needed to more accurately reflect current cardiac MRI practice. To describe the various combinations and permutations of imaging protocols with sufficient granularity for cardiac MRI of the heart, eight new codes were developed by the CPT Editorial Panel in November 2006. Four of the codes involve contrast and four without contrast. These non-contrast and with contrast, morphology and function, with flow/velocity (for physiologic assessment of values, intra cardiac shunts, etc.) and with pharmacologic stress codes will now accurately depict procedural differences in technique and physician work.

The RUC reviewed the specialty society's survey results for the entire set of codes and heard from the specialty on how the technology had changed, whereas increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT codes 75552-75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies. The RUC agreed that the new technology had increased the physician work since the typical patient is now also more complex. The RUC agreed that because of the nature of this new technology, the specialty had met the compelling evidence criteria and physician work neutrality should not apply.

75557

The RUC compared the specialty's survey results for new CPT code 75557 to its key reference service 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.26, total physician time = 50). The RUC agreed that the physician time and work RVU of 74183 supported the specialty's median survey RVU of 2.35 (60 minutes of total median survey physician time) for code 75557. The RUC also compared code 75557 to other MRI

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codes (71550 *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)* (work RVU = 1.46, physician time = 30) and 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46, physician time = 30) with similar ratios of work RVU/time and concurred that the survey median RVU was appropriate for this new code.

The RUC recommends a physician work relative value of 2.35 for code 75557.

75558

The RUC reviewed the specialty's survey results for new CPT code 75558 in relation to its key reference service 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU = 1.48, total physician time = 40). The RUC agreed that the work value to physician time ratio of 93350 supported the specialty's median survey RVU of 2.60 (65 minutes of total median survey physician time) for code 75558. In addition, the incremental work similar to that between the base code 75557 and 75558 includes flow/velocity analyses. This is analogous to the work of code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38). Adding the work values of 75557 and 93320 yields 2.73 RVUs and supports the more conservative survey median of 2.60 RVUs for code 75558.

The RUC recommends a physician work relative value of 2.60 for code 75558.

75559

The RUC reviewed the specialty's survey results for new CPT code 75559 in relation to its key reference service 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU = 1.48, total physician time = 40). The RUC agreed that the value and physician time of 75559 supported the specialty's median survey RVU of 2.95 (75 minutes of total median survey physician time) as its recommended value. In addition, the incremental work of interpreting images at rest versus at rest and with exercise has been previously assessed by the RUC. Specifically, code 78478 *Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)* (work RVU = 0.50) is a nuclear cardiology imaging add-on code used when stress imaging is added to rest imaging. Also, stress echo code 93350 (work RVU = 1.48) is 0.56 RVUs higher than rest echo code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92). These values support the survey median for 75559 of 2.95, which is 0.60 higher than the base code 75557 (recommended work RVU = 2.35).

The RUC recommends a physician work relative value of 2.95 for code 75559.

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75560
The RUC reviewed the specialty's survey results for new CPT code 75560 in relation to its key reference service 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU = 1.48, total physician time = 40). The RUC agreed that the value and physician time of 75560 supported the specialty's median survey RVU of 3.00 (80 minutes of total median survey physician time) as its recommended value. In addition, the incremental work of velocity/flow analysis, code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38), and the incremental value of imaging at stress for echo or nuclear images is 0.5 - 0.56, as discussed in the above for 75559. Adding these to the survey median RVU for the base code 75557 would yield 2.35 + 0.38 + 0.5 = 3.23. By this analysis, the survey median for 75560 of 3.00 was conservative to the RUC. Similarly, adding the increments between 75557 and 75558 (2.60 – 2.35 =0.25) and between 75557 and 75559 (2.95 – 2.35 = 0 .60) yields 2.35 +0 .25 + 0.60 = 3.20. The RUC determined that this building block approach also suggests the survey median for 75560 of 3.00 is appropriate. Lastly, the RUC also agreed that evaluation and management code 99205 *Office or other outpatient visit for the evaluation and management of a new patient...* (work RVU = 3.00), as having similar overall physician work.

1473

The RUC recommends a physician work relative value of 3.00 for code 75560.

75561
The RUC reviewed the specialty's survey results for new CPT code 75561 in relation to its key reference service 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.26) and 50 minutes. The RUC agreed that the ratio of RVU/time ratio (work RVU = 2.26, physician time = 50 minutes) for 74183 is similar to the ratio of survey medians for 75561 (work RVU = 2.75, physician time = 65 minutes). The RUC agreed that code 75561 was appropriately rank ordered within its family with a physician work relative value of 2.60.

The RUC recommends a physician work relative value of 2.60 for code 75561.

75562
The RUC reviewed the specialty's survey results for new CPT code 75562 in relation to its key reference service 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.26) and 50 minutes. The RUC agreed that the ratio of RVU/time ratio (work RVU = 2.26, physician time = 50 minutes) for 74183 is similar to the ratio of survey medians for 75561 (work RVU = 2.86, physician time = 75 minutes). The RUC agreed that code 75562 was appropriately rank ordered within its family with a physician work relative value of 2.86.

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The RUC recommends a physician work relative value of 2.86 for code 75562.

75563
The RUC compared the specialty's survey results for new CPT code 75563 to its key reference service 78492 *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress* (work RVU = 1.87, total physician time = 55). The RUC agreed that the recommended value and physician time of 75563 supported the specialty's median survey RVU of 3.00 (82.50 minutes of total median survey physician time) as its recommended value. The RUC agreed that the ratio of work RVUs to time between the key reference service and code 75563 supports the median survey work RVU of 3.00 and maintains proper rank order within the family of codes. Lastly, the RUC also agreed that evaluation and management code 99205 *Office or other outpatient visit for the evaluation and management of a new patient...* (work RVU = 3.00), as having similar overall physician work.

The RUC recommends a physician work relative value of 3.00 for code 75563.

75564
The RUC reviewed the specialty's survey results for new CPT code 75564 in relation to its key reference service 78492 *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress* (work RVU = 1.87, total physician time = 55). The RUC agreed that the value and physician time of 75564 supported the specialty's median survey RVU of 3.35 (85 minutes of total median survey physician time) as its recommended value. In addition, if 75560 is used as a base code (recommended work RVU = 3.00) and the increment between 75557 and 75561 is added (0.40 RVUs), the sum is 3.40, which is similar to the survey median for 875564 of 3.35.

The RUC recommends a physician work relative value of 3.35 for code 75564.

The RUC agreed that the median survey results were appropriate for the entire family of codes, however, the immediate post service time for each code seemed excessive at 15 minutes. The specialty society explained that there is significant time spent in discussion with the referring physician and the patient in the post service period, however it was agreed that a 5 minute reduction in the immediate post service time was warranted to reflect the time of similar procedures. The RUC recommends an immediate post-service time reduction of 5 minutes from the specialty survey results, so that there is a total of 10 minutes immediate post-service time for each service in the family.

The RUC compared the physician work required to perform the services to all the key reference codes and to the comprehensive new patient evaluation and management code 99205 (work RVU = 3.00). The RUC also reviewed existing codes with imaging contrast and without imaging contrast and agreed that the work RVU interval was similar or below others and therefore seemed appropriate for these new procedures.

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New Technology: The RUC recommends this family of codes to be added to the new technology list.

Practice Expense:
The RUC reviewed the practice expense recommendations for this new set of Cardiac MRI procedures and made minor adjustments to the clinical labor recommendations from the specialty society to reflect a more typical patient scenario. The RUC understood that these procedures would typically be performed only in the non-facility setting. The RUC recommends the attached practice expense direct inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Cardiac magnetic imaging differs from traditional MRI in its ability to provide a physiologic evaluation of cardiac function. Traditional MRI relies on static images to obtain clinical diagnoses based upon anatomic information. Improvement in spatial and temporal resolution has expanded the application from an anatomic test and includes physiologic evaluation of cardiac function. Flow and velocity assessment for valves and intracardiac shunts is performed in addition to a function and morphologic evaluation. Use 75559 and 75560 to report pharmacologic wall motion stress evaluation without contrast. Use 75563 and 75564 to report pharmacologic perfusion stress with contrast. Listed procedures may be performed independently or in the course of overall medical care. If the physician providing these services is also responsible for diagnostic workup and/or follow-up care of patient, see appropriate sections also. Only one procedure in the series 75557-75564 is appropriately reported per session. Cardiac magnetic resonance imaging studies may be performed at rest and/or pharmacologic stress. Therefore, the appropriate stress testing code for the 93015-93018 series should be reported in addition to 75559, 75560, 75563, 75564. *(For separate injection procedures for vascular radiology, see **Surgery** section, 36000-36299)* *(For cardiac catheterization procedures, see 93501-93556)*				
●75557	RR1	Cardiac magnetic resonance imaging for morphology and function without contrast material;	XXX	2.35
●75558	RR2	with flow/velocity quantification	XXX	2.60
●75559	RR3	with stress imaging	XXX	2.95
●75560	RR4	with flow/velocity quantification and stress	XXX	3.00

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●75561	RR5	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	XXX	2.60
●75562	RR6	with flow/velocity quantification	XXX	2.86
●75563	RR7	with stress imaging	XXX	3.00
●75564	RR8	with flow/velocity quantification and stress (Do not report 75557-75564 in conjunction with 76376, 76377)	XXX	3.35
D 75552		~~Cardiac magnetic resonance imaging for morphology; without contrast material~~	XXX	N/A
D 75553		~~with contrast material~~	XXX	N/A
D 75554		~~Cardiac magnetic resonance imaging for function, with or without morphology; complete study~~	XXX	N/A
D 75555		~~limited study~~	XXX	N/A
D 75556		~~Cardiac magnetic resonance imaging for velocity flow mapping~~ (75552–75556 have been deleted. To report, see 75557 - 75564)	XXX	N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75557 Tracking Number Specialty Society Recommended RVU: **2.35**
Global Period: XXX RUC Recommended RVU: **2.35**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 36-year-old man has syncope and non-sustained ventricular tachycardia suggesting origin in the right ventricle and a family history of sudden cardiac death. Cardiac MRI is ordered to assess the right ventricle structure and function.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 72%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - o Evaluate the morphological findings in multiple planes
  - o Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
- Compare to all pertinent available prior studies
- Dictate report for medical record

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin		
Specialty(s):	American College of Cardiology; American College of Radiology		
CPT Code:	75557		
Sample Size:	600	**Resp N:** 71	**Response:** 11.8 %
Sample Type:	Random		

CPT Code: 75557

		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	52.50	**150.00**	250.00	1200.00
Survey RVW:		0.60	1.99	**2.35**	2.76	6.81
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	30.00	**40.00**	60.00	160.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75557	
	Specialty Recommended
Physician Work RVU:	2.35
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	40.00

Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74183	XXX	2.26	RUC Time

CPT Descriptor Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93312	XXX	204,600	2.20	RUC Time

CPT Descriptor 1 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
78461	XXX	23,624	1.23	RUC Time

CPT Descriptor 2 Myocardial perfusion imaging; multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 16.9 %

TIME ESTIMATES (Median)	CPT Code: 75557	Key Reference CPT Code: 74183	Source of Time RUC Time
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	40.00	30.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**60.00**	**50.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.72	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.50
Urgency of medical decision making	3.54	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.42	3.58
Physical effort required	2.85	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.08	3.99
Outcome depends on the skill and judgment of physician	3.99	4.00

Estimated risk of malpractice suit with poor outcome	3.17	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.82	2.67
Intra-Service intensity/complexity	3.93	3.67
Post-Service intensity/complexity	3.15	3.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to Non-cardiology Codes:

Reference Service 74183 (Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences) with 2.26 RVU and 50 minutes of RUC time was chosen as the reference code for 75557. This supports the median survey RVU of 2.35 (65 minutes median survey times) for 75557.

75557 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 74181 (MRI abdomen w/o contrast, 1.46 RVU, 30 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75557, 71550, and 74181 are all in the range of .045 - .049.

Comparison to Other RUC-Surveyed Cardiology Codes

The consensus panel compared the survey values for 75557 to other cardiology imaging codes. Transesophageal echocardiography (93312) has 2.2 RVU and 43 minutes of RUC time. Stress nuclear imaging (78461 and 78478) have 1.73 RVU combined and combined RUC times of 35 minutes. The consensus panel agrees that 75557 is valued appropriately compared to these other 2 common cardiology imaging codes.

Building Block Method:
The consensus panel compared 75557 to 71552 (MRI Chest, RVU = 2.26) added to 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post-processing on an independent workstation, RVU = .79). It is reasonable to look at cardiac MRI as the sum of MRI of the chest (71552) plus additional post-processing (76377). Cardiac MRI is heavily dependent on post-processing.

71552	2.26 RVU	41.5 minutes total RUC time
76377	0.79 RVU	30.0 minutes total RUC time
Total	3.09 RVU	71.5 minutes RUC total time

If the value of 76377 were reduced by 50%, yielding total RVU of 2.65, this exceeds the survey median of 75557 (2.35 RVU, 65 minutes) and supports the recommendation to use the median to value this service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75552

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Cardiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,100 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Diagnostic Radiology Frequency 850 Percentage 77.27 %

Specialty Cardiology Frequency 220 Percentage 20.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 70553

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75558 Tracking Number Specialty Society Recommended RVU: **2.60**
Global Period: XXX RUC Recommended RVU: **2.60**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old post-partum female presents with heart failure, enlarged cardiac silhouette on chest x-ray and an eccentric jet of mitral regurgitation on echocardiography. MRI is requested to quantify mitral regurgitation and ventricular function.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code?

Description of Pre-Service Work:
Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - Evaluate the morphological findings in multiple planes
  - Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - Use velocity imaging protocols with post-processing to quantify valve function
- Compare to all pertinent available prior studies

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin
Specialty(s):	American College of Cardiology, American College of Radiology
CPT Code:	75558

CPT Code: 75558

Sample Size: 600	Resp N: 59	Response: 9.8 %
Sample Type: Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	12.00	50.00	**100.00**	225.00	1000.00
Survey RVW:	0.40	2.06	**2.60**	3.00	7.85
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	15.00	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75558	
	Specialty Recommended
Physician Work RVU:	2.60
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	45.00
Immediate Post Service-Time:	10.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93350	XXX	1.48	RUC Time

CPT Descriptor Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,837,459	.92	RUC Time

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71550	XXX	7,880	1.46	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 22.0 %

TIME ESTIMATES (Median)	CPT Code: 75558	Key Reference CPT Code: 93350	Source of Time
Median Pre-Service Time	10.00	0.00	
Median Intra-Service Time	45.00	0.00	
Median Immediate Post-service Time	10.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**65.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	2.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	2.77
Urgency of medical decision making	3.41	3.15
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.24	2.62
Physical effort required	2.88	2.23
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.64	1.46

Outcome depends on the skill and judgment of physician	3.98	2.46
Estimated risk of malpractice suit with poor outcome	3.08	2.46

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	312.00	1.85
Intra-Service intensity/complexity	4.12	2.15
Post-Service intensity/complexity	3.59	2.23

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to Cardiology Codes:

Reference Service 93307 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete, RVU = .92) was most frequently chosen as a reference for 75558. The consensus panel agreed that 75558 required about 3 times as much work as 93307.

Comparison to Other Non-Cardiology Codes

75558 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 74181 (MRI abdomen w/o contrast, 1.46 RVU, 30 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75558, 71550, and 74181 are all in the range of .045 - .049.

Building Block Method:

Incremental work similar to that between the base code 75557 and 75558 includes flow/velocity analyses. This is analogous to the work of 93320 (Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete, RVU = .38, 15 minutes) .

75557	2.35 RVU	65 minutes total RUC time
93320	0.38 RVU	15 minutes total RUC time
Total	2.73 RVU	80 minutes RUC total time

93320 is an add-on code, so it would not be reduced by 50%. Adding 75557 and 93320 yields 2.73 RVU and 80 minutes. This supports the more conservative survey medians of 2.6 and 70 minutes as valid for 75558.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75552

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology	How often? Commonly
Specialty Radiology	How often? Commonly
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 1000	Percentage 66.66 %
Specialty Radiology	Frequency 500	Percentage 33.33 %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,100 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 800	Percentage 72.72 %
Specialty Radiology	Frequency 300	Percentage 27.27 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 72157

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75559 Tracking Number Specialty Society Recommended RVU: **2.95**
Global Period: XXX RUC Recommended RVU: **2.95**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old hypertensive female with COPD and worsening shortness of breath scheduled for abdominal aortic aneurysm resection. Preoperative assessment for myocardial ischemia with cardiac MR is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 72%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - o Evaluate the morphological findings in multiple planes
  - o Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - o Evaluate multiple cardiac segments at incremental levels of stress for abnormal wall motion
- Compare to all pertinent available prior studies

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin		
Specialty(s):	American College of Cardiology, American College of Radiology		
CPT Code:	75559		
Sample Size: 600	**Resp N:** 54	**Response:** 9.0 %	

CPT Code: 75559

Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	6.25	**20.00**	100.00	1200.00
Survey RVW:		1.25	2.25	**2.95**	3.60	8.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	35.00	**50.00**	70.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75559	
	Specialty Recommended
Physician Work RVU:	2.95
Pre-Service Evaluation Time:	15.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	50.00
Immediate Post Service-Time:	10.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93350	XXX	1.48	RUC Time

CPT Descriptor Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71550	XXX	7,880	1.46	RUC Time

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
73721	XXX	555,723	1.35	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 35.1 %

TIME ESTIMATES (Median)	CPT Code: 75559	Key Reference CPT Code: 93350	Source of Time RUC Time
Median Pre-Service Time	15.00	0.00	
Median Intra-Service Time	50.00	40.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**75.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.65	1.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	2.56
Urgency of medical decision making	3.94	3.11
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.40	2.67
Physical effort required	3.37	2.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.79	2.50

Outcome depends on the skill and judgment of physician	4.38	3.17
Estimated risk of malpractice suit with poor outcome	3.85	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	2.37
Intra-Service intensity/complexity	4.52	2.72
Post-Service intensity/complexity	3.60	2.39

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to Other Codes

93350 (Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report) was most frequently selected as the reference for 75559. The consensus panel agreed that the work of 93350 (1.48 RVU) was about half that of 75559 (survey median 2.95 RVU). (93350 does NOT include the work of monitoring the stress treadmill test.)

75559 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 73721 (MRI, any joint of lower extremity; w/o contrast, 1.35 RVU, 20 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75559, 71550, and 73721 are all in the range of .046 – .049.

Building Block Method:

The incremental work of interpreting images at rest versus at rest and with exercise has been previously assessed by the RUC. Specifically, 78478 is a nuclear cardiology imaging add-on code used when stress imaging is added to rest imaging (RVU = .5). Also, 93350 (stress echo, 1.48 RVU) is .56 RVU higher than 93307 (rest echo, .92 RVU). These values support the survey median for 75559 of 2.95, which is .6 higher than the 75557 base code (2.35 RVU).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75553

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2500	Percentage 55.55 %
Specialty Radiology	Frequency 2000	Percentage 44.44 %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,750 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 1500	Percentage 54.54 %
Specialty Radiology	Frequency 1250	Percentage 45.45 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 93503

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75560 Tracking Number Specialty Society Recommended RVU: **3.00**
Global Period: XXX RUC Recommended RVU: **3.00**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male smoker has a diagnosis of mitral valve prolapse, mitral valve regurgitation and chest pain. The referring physician requests complete assessment of left ventricular and right ventricular function, quantification of mitral insufficiency, and evaluation for myocardial ischemia.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 65%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - o Evaluate the morphological findings in multiple planes
  - o Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - o Evaluate multiple cardiac segments at incremental levels of stress for abnormal wall motion
- Compare to all pertinent available prior studies

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin		
Specialty(s):	American College of Cardiology; American College of Radiology		
CPT Code:	75560		
Sample Size: 600	**Resp N:** 48	**Response:** 8.0 %	

CPT Code: 75560

Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	5.00	**20.00**	100.00	1200.00
Survey RVW:		1.25	2.50	**3.00**	3.60	9.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		15.00	40.00	**55.00**	80.00	145.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75560		
		Specialty Recommended
Physician Work RVU:		3.00
Pre-Service Evaluation Time:		15.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		55.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93350	XXX	1.48	RUC Time

CPT Descriptor Echocardiology, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,837,459	.92	RUC Time

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71550	XXX	7,880	1.46	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)	CPT Code: 75560	Key Reference CPT Code: 93350	Source of Time RUC Time
Median Pre-Service Time	15.00	0.00	
Median Intra-Service Time	55.00	40.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**80.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.96	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	2.94
Urgency of medical decision making	3.96	3.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.49	2.88
Physical effort required	3.27	2.31
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.71	2.63

Outcome depends on the skill and judgment of physician	4.49	3.44
Estimated risk of malpractice suit with poor outcome	3.90	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.39	2.69
Intra-Service intensity/complexity	4.53	3.19
Post-Service intensity/complexity	3.78	2.69

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to Other Codes

93350 (Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report) was most frequently selected as the reference for 75560. The consensus panel agreed that the work of 75560 (survey median 3.0 RVU) was more than twice that of 93350 (1.48 RVU).

75560 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 74181 (MRI abdomen w/o contrast, 1.46 RVU, 30 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75560 (.042) is less than IWPUT for 71550, and (both .049).

Building Block Method:

The incremental work of velocity/flow analysis (93320) for echo is .38, and the incremental value of imaging at stress for echo or nuclear images is .5 - .56, as discussed in the SOR for 73555X3. Adding these to the survey median RVU for the base code 75557 would yield 2.35 + .38 + .5 = 3.23. By this analysis, the survey median for 75560 of 3.0 is conservative. Similarly, adding the increments between 75557 and 75558 (2.6 - 2.35 =.25) and between 75557 and 75559 (2.95 - 2.35 = .6) would yield 2.35 + .25 + .6 = 3.2. This also suggests the survey median for 75560 of 3.0 is conservative.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75553

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2000	Percentage 50.00 %
Specialty Radiology	Frequency 2000	Percentage 50.00 %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 1500	Percentage 60.00 %
Specialty Radiology	Frequency 1000	Percentage 40.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99205

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75561 Tracking Number Specialty Society Recommended RVU: **2.60**
Global Period: XXX RUC Recommended RVU: **2.60**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male with multi-vessel coronary artery disease and severely reduced left ventricular systolic function is scheduled for bypass surgery. A cardiac MRI with contrast material is scheduled to assess cardiac myocardial viability prior to coronary bypass surgery.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 66.67%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
\• Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - o Evaluate the morphological findings in multiple planes
  - o Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - o Interpret pre- and post-contrast images to assess myocardial viability
- Compare to all pertinent available prior studies
- Dictate report for medical record

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin
Specialty(s):	American College of Cardiology; American College of Radiology
CPT Code:	75561

CPT Code: 75561

Sample Size: 600	Resp N: 52	Response: 8.6 %
Sample Type: Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	15.00	50.00	**125.00**	250.00	1200.00
Survey RVW:	1.25	2.20	**2.60**	3.00	7.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	15.00	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75561		
		Specialty Recommended
Physician Work RVU:		2.60
Pre-Service Evaluation Time:		10.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		45.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78459	XXX	1.50	RUC Time

CPT Descriptor Myocardial imaging, positron emission tomography (PET), metabolic evaluation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
78465	XXX	3,013,393	1.46	RUC Time

CPT Descriptor 1 Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
74181	XXX	73,654	1.46	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 19.2 %

TIME ESTIMATES (Median)

	CPT Code: 75561	Key Reference CPT Code: 78459	Source of Time RUC Time
Median Pre-Service Time	10.00	0.00	
Median Intra-Service Time	45.00	65.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**65.00**	**65.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.84	2.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	2.40
Urgency of medical decision making	3.78	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	4.02	2.60
Physical effort required	2.96	2.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.94	1.60
Outcome depends on the skill and judgment of physician	4.12	2.70

Estimated risk of malpractice suit with poor outcome	3.42	2.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.96	2.00
Intra-Service intensity/complexity	3.88	2.60
Post-Service intensity/complexity	3.31	2.50

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to other Codes

Reference Service 74183 (Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences) with 2.26 RVU and 50 minutes of RUC time was most frequently chosen

as the reference code for 75561. The ratio of RVU/time ratio (2.26/50 minutes) for 74183 is similar to the ratio of survey medians for 75561 (2.75 RVU/70 minutes)

75561 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 74181 (MRI abdomen w/o contrast, 1.46 RVU, 30 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75561, 71550, and 74181 are all .049. Also, the recommended value for 75561 is conservative compared to 71551 (MRI chest with contrast, 1.73 RVU, 45 minutes) and 74182 (MRI abdomen with contrast, 1.73 RVU, 45 minutes) with IWPUTs of .051 - .059.

Building Block Method

The incremental work required for imaging with contrast (75561) compared to without contrast (75557) has previously been evaluated by the RUC. Examples include 71550 vs 71551 (MRI chest without versus with contrast, .27 RVU difference), 74181 vs 74182 (MRI abdomen without versus with contrast, .27 RVU difference), and 70551 vs 7052 (MRI brain without versus with contrast, .3 RVU difference). Finally, the incremental work between cardiac MRI without versus with contrast was valued previously (2002) at .4 RVU. If the survey median RVU for 75557 (2.35) is used as a base, adding an increment of .27 – 4 yields a value of 2.62 – 2.75, close to the survey median for 75561 of 2.75.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75552

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology	How often? Commonly
Specialty Radiology	How often? Commonly
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 1100	Percentage 55.00 %
Specialty Radiology	Frequency 900	Percentage 45.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,200 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiolog	Frequency 600	Percentage 50.00 %
Specialty Radiology	Frequency 600	Percentage 50.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 72157

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75562 Tracking Number
Global Period: XXX

Specialty Society Recommended RVU: **2.86**
RUC Recommended RVU: **2.86**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male hemodialysis patient with heart failure is referred for evaluation. Echocardiogram shows myocardial speckling and aortic insufficiency of indeterminant severity. An MRI is requested to quantify the ejection fraction, the severity of the aortic regurgitation, and to assess for infiltrative myocardial disease.

Percentage of Survey Respondents who found Vignette to be Typical: 87.50%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 66%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - Evaluate the morphological findings in multiple planes
  - Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - Use velocity imaging protocols with post-processing to quantify valve function
  - Interpret pre- and post-contrast images to assess myocardial viability and infiltrative disease
- Compare to all pertinent available prior studies
- Dictate report for medical record

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin
Specialty(s):	American College of Cardiology; American College of Radiology
CPT Code:	75562

CPT Code: 75562

Sample Size: 600	Resp N: 50	Response: 8.3 %
Sample Type: Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	20.00	**50.00**	150.00	1200.00
Survey RVW:	1.00	2.40	**2.86**	3.40	9.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	32.50	**55.00**	65.00	150.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75562	
	Specialty Recommended
Physician Work RVU:	2.86
Pre-Service Evaluation Time:	10.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	55.00

Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74183	XXX	2.26	RUC Time

CPT Descriptor Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71550	XXX	7,880	1.46	RUC Time

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
73721	XXX	555,923	1.35	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.0 %

TIME ESTIMATES (Median)	CPT Code: 75562	Key Reference CPT Code: 74183	Source of Time RUC Time
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	55.00	30.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**75.00**	**50.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.34	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.98	3.32
Urgency of medical decision making	3.20	3.36
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.11	4.18
Physical effort required	2.63	2.36
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.50	2.91
Outcome depends on the skill and judgment of physician	3.09	4.09

Estimated risk of malpractice suit with poor outcome	2.89	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	2.64
Intra-Service intensity/complexity	2.80	3.55
Post-Service intensity/complexity	2.64	2.91

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to other Codes

Reference Service 74183 (Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences) with 2.26 RVU and 50 minutes of RUC time was chosen as the

reference code for 75562. The RVU/time ratio of 2.26/50 minutes is similar to the survey medians for 75562 (2.86 RVU/80 minutes).

75562 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 73721(MRI lower extremity w/o contrast. 1.35 RVU, 20 minutes) recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75562 (.042) is less than that of 71550 (.049). Also, the recommended value for 75562 is conservative compared to 71551 (MRI chest with contrast, 1.73 RVU, 45 minutes) and 74182 (MRI abdomen with contrast, 1.73 RVU, 45 minutes) with IWPUTs of .051 - .059.

Building Block Methods
The incremental work of 75562 compared to 75561 would be expected to be similar to the difference between 75557 and 75558, which was .25. By this measure the difference in survey medians between 75561 and 75562 of only .11 is conservative. If 75561 is used as the base code (survey median RVU = 2.75) and the value of 93320 (echo Doppler flow analysis, .38 RVU) is added (as discussed in the SOR for 75558), the sum of 3.13 far exceeds the survey median of 2.86. The consensus panel agreed that either building block approach yields a value higher than the survey median, suggesting that the survey median is a conservative value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75554

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Commonly

Specialty Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
5,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2800	Percentage 56.00 %	
Specialty Radiology	Frequency 1500	Percentage 30.00 %	
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 95872

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75563 Tracking Number Specialty Society Recommended RVU: **3.00**
Global Period: XXX RUC Recommended RVU: **3.00**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old diabetic male with new onset chest pain has known severe, diffuse, three vessel coronary artery diseases, status post coronary artery bypass surgery and known saphenous vein graft disease, referred for adenosine stress to determine the culprit lesion for possible cardiac intervention depending on the remaining viable myocardium at risk.

Percentage of Survey Respondents who found Vignette to be Typical: 87.50%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 71%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - o Evaluate the morphological findings in multiple planes
  - o
  - o Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - o Evaluate multiple cardiac segments at incremental levels of stress for abnormal wall motion and viability
  - o Interpret pre- and post-contrast images to assess myocardial ischemia and viability
- Compare to all pertinent available prior studies
- Dictate report for medical record

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin
Specialty(s):	American College of Cardiology; American College of Radiology

CPT Code:	75563					
Sample Size:	600	**Resp N:**	46	**Response:** 7.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	13.75	**27.50**	112.50	1200.00
Survey RVW:		1.00	2.30	**3.00**	3.53	10.00
Pre-Service Evaluation Time:				**12.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	41.25	**60.00**	78.25	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75563		
		Specialty Recommended
Physician Work RVU:		3.00
Pre-Service Evaluation Time:		12.5
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78492	XXX	1.86	RUC Time

CPT Descriptor Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71550	XXX	7,880	1.46	RUC Time

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
73721	XXX	555,923	1.35	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 26.0 %

TIME ESTIMATES (Median)	CPT Code: 75563	Key Reference CPT Code: 78492	Source of Time RUC Time
Median Pre-Service Time	12.50	0.00	
Median Intra-Service Time	60.00	55.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**82.50**	**55.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.22	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.26	2.75
Urgency of medical decision making	4.16	3.42
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.43	3.00
Physical effort required	3.50	2.83
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.76	2.50
Outcome depends on the skill and judgment of physician	4.48	2.75

Estimated risk of malpractice suit with poor outcome	3.85	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.65	2.83
Intra-Service intensity/complexity	4.61	2.92
Post-Service intensity/complexity	4.02	3.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to other codes

Reference Service 78492 (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress) was most frequently chosen as the reference code for 75563. The ratio of work/time (1.87 RVU/55 minutes) of 78492 is higher than the work/time of 75563 as surveyed at 3.0/82.5 minutes.

75563 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 74181 (MRI abdomen w/o contrast, 1.46 RVU, 30 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75563 (.040) is less than that of 71550 and 74181 (.049). Also, the recommended value for 75563 is conservative compared to 71551 (MRI chest with contrast, 1.73 RVU, 45 minutes) and 74182 (MRI abdomen with contrast, 1.73 RVU, 45 minutes) with IWPUTs of .051 - .059.

Building Block Method

The incremental work of interpreting images at rest versus at rest and with exercise has been previously assessed by the RUC. Specifically, 78478 is a nuclear cardiology imaging add-on code used when stress imaging is added to rest imaging (RVU = .5). Also, 93350 (stress echo, 1.48 RVU) is .56 RVU higher than 93307 (rest echo, .92 RVU). If 75561 is the base code (survey median 2.75 RVU) and one adds an increment of .5, the sum is 3.25, higher than the survey median of 3.

Similarly, if 75559 (MRI cardiac stress without contrast) is used as the base code (survey median 2.95) and the incremental work associated with contrast vs no contrast (.3 RVU, as discussed in the SOR for 75561), the sum of 3.25 is higher than the survey median for 75563 of 3.0.

Finally, if 75559 (MRI cardiac stress without contrast) is used as the base code (survey median 2.95) and the difference between 75557 and 75560 is used to approximate the incremental work of contrast (.4 RVU), the sum of 3.35 is higher than the survey median for 75563 of 3.0.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75554

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology	How often? Commonly
Specialty Radiology	How often? Commonly
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2800	Percentage 56.00 %
Specialty Radiology	Frequency 1500	Percentage 30.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
5,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2800	Percentage 56.00 %
Specialty Radiology	Frequency 1500	Percentage 30.00 %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99205

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75564 Tracking Number Specialty Society Recommended RVU: **3.35**
Global Period: XXX RUC Recommended RVU: **3.35**

CPT Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification with and stress

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old diabetic male with chest pain and known ischemic cardiomyopathy has mitral regurgitation and severe, diffuse, three vessel coronary and saphenous vein graft disease status post coronary artery bypass. The referring physician requests assessment of severity of mitral regurgitation, myocardial viability, and the culprit vessel causing ischemia for targeted intervention versus a redo open heart procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 77%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review medical chart and records
- Review any prior imaging studies
- Review protocol with technologist
- Describe procedure to patient and obtain consent as needed
- Review source imaging data
- Supervise administration of anxiolytic where applicable

Description of Intra-Service Work:
- Supervise set-up for different anatomical imaging planes
- Review study images and provide input on whether to obtain additional imaging planes or sequences
- Supervise and/or create reconstructions of the heart and mediastinum using an independent workstation
- Adjust the projection of the reconstructions to optimize visualization of anatomy or pathology
- Interpret the source and reformatted images resulting from the study, typically including cine review with the following specific activities:
  - o Evaluate the morphological findings in multiple planes
  - o Assess biventricular function with ejection fraction and characterization of wall motion abnormalities
  - o Use velocity imaging protocols with post-processing to quantify valve function
  - o Evaluate multiple cardiac segemnts at incremental levels of stress for abnormal wall motion and viability
  - o Interpret pre- and post-contrast images to assess myocardial viability
- Evaluate multiple cardiac segemnts at incremental levels of stress for abnormal wall motion Compare to all pertinent available prior studies
- Dictate report for medical record

Description of Post-Service Work:
- Review and sign report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Dr. Edward T. Martin; Dr. Geraldine McGinty; Dr. Jonathan Berlin

Specialty(s):	American College of Cardiology; American College of Radiology					
CPT Code:	75564					
Sample Size:	600	**Resp N:**	44	**Response:** 7.3 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	5.00	**25.00**	100.00	1200.00
Survey RVW:		1.25	2.00	**3.35**	4.19	12.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	45.00	**60.00**	85.00	120.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 75564	
	Specialty Recommended
Physician Work RVU:	3.35
Pre-Service Evaluation Time:	15.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	60.00
Immediate Post Service-Time:	10.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78492	XXX	1.86	RUC Time

CPT Descriptor Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
71550	XXX	7,880	1.46	RUC Time

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
73721	XXX	555,923	1.35	RUC Time

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 26.0 %

TIME ESTIMATES (Median)	CPT Code: 75564	Key Reference CPT Code: 78492	Source of Time RUC Time
Median Pre-Service Time	15.00	0.00	
Median Intra-Service Time	60.00	55.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**85.00**	**55.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.37	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.52	2.58
Urgency of medical decision making	4.27	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.57	2.92
Physical effort required	3.53	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.70	2.25
Outcome depends on the skill and judgment of physician	4.63	2.42

Estimated risk of malpractice suit with poor outcome	3.87	3.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.89	2.67
Intra-Service intensity/complexity	4.76	3.00
Post-Service intensity/complexity	4.04	2.67

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
The survey was reviewed by a consensus panel of the specialty societies' RUC committees. The survey data from cardiologists and radiologists were merged and a single recommendation is submitted for each code.

Compelling Evidence for Change: For all of the codes in this family the specialty societies believe that the increased work value is due to new physician work. Increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT Code 75552 - 75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies.

Current cine images are clearer, providing better spatial and contrast resolution. Therefore, a more complete analysis is now done. The MR system now is used for the full evaluation of the patient's heart. With quicker imaging, more planes are obtained in a shorter time allowing a more detailed evaluation and producing more images. With shorter breath-hold times, sicker patients can now be imaged and analyzed, leading to an increase in overall work and complexity. As the capabilities of MR imaging have become better known, the complexity of patients referred for MR imaging has increased. Flow techniques have become validated in the clinical arena and are now being used to measure and quantify pulmonary-to-systemic flow (Qp/Qs) ratios, velocities (which allow valvular stenosis evaluation), and regurgitant fractions that provide precise assessments of valvular regurgitation. These new techniques have greatly enhanced the diagnostic capabilities of cardiac MR imaging. In the section below, we use several methods to support the validity of the survey median RVU proposed for this code.

Magnitude Estimation and Rank Order:
The specialty societies agreed that median survey value places this code in correct rank order relative to the other 7 cardiac MRI codes. The expert panel reviewed the survey data and agreed that the survey median RVU for this code seems appropriate.

Comparison to other codes

Reference Service 78492 (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress) was most frequently chosen as the reference code for 75563. The consensus panel agreed that 75564 (survey median 3.35 RVU) was more than twice the work of 78492.

75564 was compared to other MRI codes with similar ratios of RVU/time. These included 71550 (MRI chest w/o contrast, 1.46 RVU, 30 minutes) and 74181 (MRI abdomen w/o contrast, 1.46 RVU, 30 minutes). Recognizing that IWPUT for imaging services has not been validated, the consensus panel noted that IWPUT for 75564 (.045) is less than that of 71550 and 74181 (.049). Also, the recommended value for 75564 is conservative compared to 71551 (MRI chest with contrast, 1.73 RVU, 45 minutes) and 74182 (MRI abdomen with contrast, 1.73 RVU, 45 minutes) with IWPUTs of .051 - .059.

Building Block Method

If 75560 is used as the base code (survey median 3.0) and the increment between non-cardiac MRI codes associated with contrast versus no contrast is added (.3) (rationale discussed in SOR for 75561), the sum of 3.3 confirms the survey median of 75564 of 3.35.

If 75560 is used as the base code (survey median 3.0) and the increment between 75557 and 75561 is added (.4 RVU), the sum is 3.4, which further confirms the survey median of 75564 of 3.35.

If 75561 is used as the base code (survey median 2.75) and to this is added the increment associated with exercise (.5 RVU) and flow/velocity mapping (.38 RVU), the sum of 2.75 + .5 +.38 = 3.63 exceeds the survey median for 75564 of 3.35.

Thus, all 3 building block methods support the survey median of 3.35 RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75554

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology	How often? Commonly
Specialty Radiology	How often? Commonly
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2800	Percentage 56.00 %
Specialty Radiology	Frequency 1500	Percentage 30.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
5,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Cardiology	Frequency 2800	Percentage 56.00 %
Specialty Radiology	Frequency 1500	Percentage 30.00 %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 33233

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75557

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material;

Sample Size: 600 Response Rate: (%): 11.8 Global Period: XXX

Geographic Practice Setting %: Rural 10 Suburban 24 Urban 66

Type of Practice %:
- 0 Solo Practice
- 30 Single Specialty Group
- 20 Multispecialty Group
- 50 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the intra-service period a MR Technologist typically performs the following activities:

- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- prep chest; apply ekg pads; apply ekg leads; apply coil
- wrap respirator belt,
- Assist physician during procedure

Post-Service: Clinical Labor Activities

During the post-service period a MR Technologist typically performs the following activities:

- save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75558

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification

Sample Size: 600 Response Rate: (%): 9.8 Global Period: XXX

Geographic Practice Setting %: Rural 9.3 Suburban 23.3 Urban 67.4

Type of Practice %:
- 0 Solo Practice
- 25.6 Single Specialty Group
- 23.3 Multispecialty Group
- 51.2 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the intra-service period a MR Technologist typically performs the following activities:

- Review charts

- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- prep chest; apply ekg pads; apply ekg leads; apply coil
- wrap respirator belt,
- Assist physician during procedure

Post-Service: Clinical Labor Activities

During the post-service period a MR Technologist typically performs the following activities:

- save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75559

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging

Sample Size: 600 Response Rate: (%): 9.0 Global Period: XXX

Geographic Practice Setting %: Rural 9.3 Suburban 23.3 Urban 67.1

Type of Practice %:
- 0 Solo Practice
- 25.6 Single Specialty Group
- 22.9 Multispecialty Group
- 50.7 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PEAC approved packages and PEA approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Review charts
- Greet patient and provide gowning

- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- prep chest; apply ekg pads; apply ekg leads; apply coil
- wrap respirator belt,
- Assist physician during procedure

During the intra-service period a RN/LPN/MTA staff type typically performs the following activities:

- set up meds pump, instruct pt and discuss possible side effects
- get baseline vitals both in and out of the scanner
- adjust and administer meds
- monitor vitals throughout
- study as well as record vital signs
- recover to baseline post ekg

Post-Service: Clinical Labor Activities

During the pre-service period an MR Technologist staff type typically performs the following activities:

- save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75560

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress

Sample Size: 600 Response Rate: (%): 8.0 Global Period: XXX

Geographic Practice Setting %: Rural 11.4 Suburban 25.7 Urban 62.9

Type of Practice %:
- 0 Solo Practice
- 31.4 Single Specialty Group
- 25.7 Multispecialty Group
- 42.9 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Review charts

- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- prep chest; apply ekg pads; apply ekg leads; apply coil
- wrap respirator belt,
- Assist physician during procedure

During the intra-service period a RN/LPN/MTA staff type typically performs the following activities:

- set up meds pump, instruct pt and discuss possible side effects
- get baseline vitals both in and out of the scanner
- adjust and administer meds
- monitor vitals throughout
- study as well as record vital signs
- recover to baseline post ekg

Post-Service: Clinical Labor Activities

During the pre-service period an MR Technologist staff type typically performs the following activities:

- save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75561

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;

Sample Size: 600 Response Rate: (%): 8.6 Global Period: XXX

Geographic Practice Setting %: Rural 11.8 Suburban 26.5 Urban 61.8

Type of Practice %:
- 0 Solo Practice
- 29.4 Single Specialty Group
- 26.5 Multispecialty Group
- 44.1 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the intra-service period a MR Technologist typically performs the following activities:

- Review charts
- Greet patient and provide gowning

- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- prep chest; apply ekg pads; apply ekg leads; apply coil
- wrap respirator belt,
- Assist physician during procedure

Post-Service: Clinical Labor Activities

During the post-service period a MR Technologist typically performs the following activities:

- save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75562

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification

Sample Size: 600 Response Rate: (%): 8.3 Global Period: XXX

Geographic Practice Setting %: Rural 12.1 Suburban 27.3 Urban 60.6

Type of Practice %:
- 0 Solo Practice
- 30.3 Single Specialty Group
- 27.3 Multispecialty Group
- 42.4 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the intra-service period a MR Technologist typically performs the following activities:

- Review charts

- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- prep chest; apply ekg pads; apply ekg leads; apply coil
- wrap respirator belt,
- Assist physician during procedure

Post-Service: Clinical Labor Activities

During the post-service period a MR Technologist typically performs the following activities:

- save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75563

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging

Sample Size: 600 Response Rate: (%): 7.6 Global Period: XXX

Geographic Practice Setting %: Rural 9.7 Suburban 29.0 Urban 61.3

Type of Practice %:
- 0 Solo Practice
- 32.3 Single Specialty Group
- 25.8 Multispecialty Group
- 41.9 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

During the pre-service period an RN/LPN/MTA staff type typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Review charts
- Greet patient and provide gowning
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- start 2 iv's, explain test ,prep chest apply ekg pads and leads
- apply coil engage resp belt,get pt comfortable
- give pt headphones, advance into scanner, maintain communication w/ insrtuctions. Scan basic prot. Bring patint out to hook up to bp cuff and sao2 turn invivo monitor on.
- Explain test to pt. advance pt into scanner. Scan stress prot. Inject contrast. Exit patient
- unhook all equipment from patient
- network and save exam to optical disk

During the intra-service period a RN/LPN/MTA staff type typically performs the following activities:

- set up meds pump. Instruct and discuss side effects w/pt. mix meds
- get baseline vitals both in and out of scanner.monitor vitals until stress testing is complete.
- recover pt to baseline.
- Administer any additional meds if needed
- Assist physician during procedure

Post-Service: Clinical Labor Activities

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Day Global Period
Non Facility Direct Inputs
75564

CPT Long Descriptor: Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress

Sample Size: 600 Response Rate: (%): 7.5 Global Period: XXX

Geographic Practice Setting %: Rural 9.9 Suburban 29.0 Urban 60.1

Type of Practice %:
- 0 Solo Practice
- 32.0 Single Specialty Group
- 25.8 Multispecialty Group
- 40.2 Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Cardiology (ACC) convened representatives of both the ACC and the Society for Cardiovascular Magnetic Resonance (SCMR) to discuss practice expense inputs. Individuals who participated included cardiologists from across the country representing cardiovascular outpatient centers and private practices. The representatives met via conference call and one (1) face to face meeting to review the data. Survey data from the American College of Radiology (ACR) collected via a similar process was merged into a single recommendation for each code. The recommendations were presented to the ACC's Cardiovascular Relative Value Update Committee (CVRUC). The CVRUC contains 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PERC approved packages and PERC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service period an MR Technologist staff type typically performs the following activities:

During the pre-service period an RN/LPN/MTA staff type typically performs the following activities:

- Review/read x-ray, lab, and pathology reports

Intra-Service Clinical Labor Activities:

CPT Code:_____
Specialty Society('s)_____

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Review charts
- Greet patient and provide gowning
- Provide pre-service education/obtain consent
- Prepare room, equipment and supplies
- start 2 iv's, explain test ,prep chest apply ekg pads and leads
- apply coil engage resp belt,get pt comfortable
- give pt headphones, advance into scanner, maintain communication w/ insrtuctions. Scan basic prot. Bring patint out to hook up to bp cuff and sao2 turn invivo monitor on.
- Explain test to pt. advance pt into scanner. Scan stress prot. Inject contrast. Exit patient
- unhook all equipment from patient
- network and save exam to optical disk

During the intra-service period a RN/LPN/MTA staff type typically performs the following activities:

- set up meds pump. Instruct and discuss side effects w/pt. mix meds
- get baseline vitals both in and out of scanner.monitor vitals until stress testing is complete.
- recover pt to baseline.
- Administer any additional meds if needed
- Assist physician during procedure

Post-Service: Clinical Labor Activities

During the pre-service period an MR Technologist staff type typically performs the following activities:

- Save to optical disk; make copies for referring physician
- Conduct follow-up phone calls with patient/family

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

	A	B	C	D	E	F	G	H	I	J	K
1											
2				75557		75558		75559		75560	
3	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Cardiac magnetic resonance imaging for morphology and function without contrast material;		Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification		Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging		Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD	XXX									
6	TOTAL CLINICAL LABOR TIME			46.0	0.0	56.0	0.0	65.0	0.0	75.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			46.0	0.0	56.0	0.0	65.0	0.0	75.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10											
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility	L047A	MR Tech	0		0		0		0	
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity (please specify)										
18	End:When patient enters office/facility for surgery/procedure										
19											
20	Start: When patient enters office/facility for surgery/procedure										
21	Pre-service services										
22	Review charts			2		2		2		2	
23	Greet patient and provide gowning	L047A	MR Tech	3		3		3		3	
24	Obtain vital signs	L047A	MR Tech	3		3		3		3	
25	Provide pre-service education/obtain consent										
26	Prepare room, equipment, supplies	L047A	MR Tech	2		2		2		2	
27	Setup scope (non facility setting only)										
28	Prepare and position patient/ monitor patient/ set up IV	L047A	MR Tech	2		2		2		2	
29	Sedate/apply anesthesia										
30	Intra-service										
31	Perform procedure	L047A	MR Tech	27		37		45		55	
32	Post-Service										
33	Monitor pt. following service/check tubes, monitors, drains										
34	Clean room/equipment by physician staff	L047A	MR Tech	3		3		3		3	
35	Clean Scope										
36	Clean Surgical Instrument Package										
37	Post Processing	L047A	MR Tech	3		3		3		3	
38	Review/read X-ray, lab, and pathology reports										
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
40	Discharge day management 99238 --12 minutes										
41	Other Clinical Activity (remove ivs and ECG & bellows)			1		1		2		2	
42	End: Patient leaves office										
43											
44	Start: Patient leaves office/facility			No Post Operative Follow up							
45	Conduct phone calls/call in prescriptions										

1550

	A	B	C	D	E	F	G	H	I	J	K
2				75557		75558		75559		75560	
3	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Cardiac magnetic resonance imaging for morphology and function without contrast material;		Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification		Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging		Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
57	[illegible]	CMS Code	Unit								
58	Patient Gown	11107	1	1		1		1		1	
59	Pillow Case	11112	1	1		1		1		1	
60	Gloves - nonsterile	11302	2	2		2		2		2	
61	Swab, alcohol	31101	2	0		0		2		2	
62	Gauze	31505	2	2		2		4		4	
63	Earplugs	SJ018	2	1		1		1		1	
64	povidone swabsticks (3pack uou)	SJ043	2	0		0		2		2	
65	Electrode, ECG (single)	SD053	1	4		4		4		4	
66	Syringe, 20 ml	SC053	1					1		1	
67	Tubing, latex	SD130	1 foot					5		5	
68	Sensor, airflow cannula	SD112	1					1		1	
69	bandage, elastic, self-adherent wrap 1in (Coban)	SG014	1					1		1	
70	drape, non-sterile, sheet 40 X 60 in	SB006	1	1		1		1		1	
71	syringe 10-12ml	SC051	1					2		2	
72	needle, 18-19g, filter	SC027	1					2		2	
73	phosphate buffered saline solution	SL107	1ml	0		0		40		40	
74	cotton balls, sterile	SG082	1					4		4	
75	Kit, IV starter	SA019	1					1		1	
76	sodium chloride 0.9% inj bateriostatic (30ml uou)	SH068	1					1		1	
77	computer media, optical disk 2.6gb	SK016	1	1		1		1		1	
78	power injector supplies							0		0	
79	infusion pump supplies							1		1	
80	nuprep gel			1		1		1		1	
81	[illegible]	CMS Code									
82	Room, MR	EL008		1		1		1		1	
83	computer workstation, 3D reconstruction CT-MR	ED104		1		1		1		1	
84	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		1		1		1		1	
85	Cardiac Coil	see invoice		1		1		1			
86	Infusion Pump (MR compatible)							1		1	

1551

	A	B	C	L	M	N	O	P	Q	R	S
1											
2				75561		75562		75563		75564	
3	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD	XXX									
6	TOTAL CLINICAL LABOR TIME			67.0	0.0	77.0	0.0	78.0	0.0	88.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			67.0	0.0	77.0	0.0	78.0	0.0	88.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10											
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility	L047A	MR Tech	0		0		0		0	
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity (please specify)										
18	**End:When patient enters office/facility for surgery/procedure**										
19											
20	**Start: When patient enters office/facility for surgery/procedure**										
21	**Pre-service services**										
22	Review charts			2		2		2		2	
23	Greet patient and provide gowning	L047A	MR Tech	3		3		3		3	
24	Obtain vital signs	L047A	MR Tech	3		3		3		3	
25	Provide pre-service education/obtain consent										
26	Prepare room, equipment, supplies	L047A	MR Tech	2		2		2		2	
27	Setup scope (non facility setting only)										
28	Prepare and position patient/ monitor patient/ set up IV	L047A	MR Tech	4		4		4		4	
29	Sedate/apply anesthesia										
30	**Intra-service**										
31	Perform procedure	L047A	MR Tech	45		55		55		65	
32	**Post-Service**										
33	Monitor pt. following service/check tubes, monitors, drains										
34	Clean room/equipment by physician staff	L047A	MR Tech	3		3		3		3	
35	Clean Scope										
36	Clean Surgical Instrument Package										
37	Post Processing	L047A	MR Tech	3		3		3		3	
38	Review/read X-ray, lab, and pathology reports										
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
40	Discharge day management 99238 –12 minutes										
41	Other Clinical Activity (remove ivs and ECG & bellows)			2		2		3		3	
42	**End: Patient leaves office**										
43											
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions										

1552

	A	B	C	L	M	N	O	P	Q	R	S
2			-	75561		75562		75563		75564	
3	Meeting Date: April 2007 AMA/Specialty Society RVS Update Committee Recommendation			Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
57	[illegible]	CMS CODE									
58	Patient Gown	11107	1	1		1		1		1	
59	Pillow Case	11112	1	1		1		1		1	
60	Gloves - nonsterile	11302	2	2		2		2		2	
61	Swab, alcohol	31101	2	2		2		2		2	
62	Gauze	31505	2	2		2		4		4	
63	Earplugs	SJ018	2	1		1		1		1	
64	povidone swabsticks (3pack uou)	SJ043	2	2		2		2		2	
65	Electrode, ECG (single)	SD053	1	4		4		4		4	
66	Syringe, 20 ml	SC053	1	2		2		1		1	
67	Tubing, latex	SD130	1 foot					4		4	
68	Sensor, airflow cannula	SD112	1					2		2	
69	bandage, elastic, self-adherent wrap 1in (Coban)	SG014	1					1		1	
70	drape, non-sterile, sheet 40 X 60 in	SB006	1	1		1		1		1	
71	syringe 10-12ml	SC051	1					2		2	
72	needle, 18-19g, filter	SC027	1	2		2		4		4	
73	phosphate buffered saline solution	SL107	1ml	40		40		40		40	
74	cotton balls, sterile	SG082	1	4		4		4		4	
75	Kit, IV starter	SA019	1	1		1		2		2	
76	sodium chloride 0.9% inj bateriostatic (30ml uou)	SH068	1	1		1		1		1	
77	computer media, optical disk 2.6gb	SK016	1	1		1		1		1	
78	power injector supplies			1		1		1		1	
79	infusion pump supplies			0		0		1		1	
80	nuprep gel			1		1		1		1	
81	[illegible]	CMS CODE									
82	Room, MR	EL008		1		1		1		1	
83	computer workstation, 3D reconstruction CT-MR	ED104		1		1		1		1	
84	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		1		1		1		1	
85	Cardiac Coil	see invoice									
86	Infusion Pump (MR compatible)							1		1	

1553

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Brain and Cerebrospinal Fluid Imaging

The CPT Editorial Panel edited the Nervous System Section, CPT codes 78600-78699, to provide a clearer description of the services describing the number of views captured in various brain imaging services based on current medical practice. The CPT Editorial Panel edited five codes and deleted one code. The CPT Editorial Panel made editorial changes to the descriptors, which did not impact the physician work, however the specialty society recommended edits to the practice expense inputs.

Practice Expense:
The RUC recommends modifications to the practice expense for CPT codes 78600 *Brain imaging, less than four static views*, 78606 *Brain imaging, minimum four static views; with vascular flow* and 78610 *Brain imaging, vascular flow only*. After review of the number of films for the following brain imaging procedures, the RUC recommends the following changes to the direct practice expense inputs:

CPT 78600 reduce the number of films and developer from (2) in to (1)
CPT 78606 reduce the number of films and developer from currently listed (4) to (2)
CPT 78610 reduce the number of films and developer from currently listed (2) to (1)

All other practice expense inputs for this family of codes are consistent with the revised descriptors.

The rationale for these changes is:
- Less than or greater than four views would require (1) one film and developer
- Adding flow to images requires one additional film and developer and is consistent with other nuclear medicine SPECT single study procedures where two (2) films and developer are required.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
e▲78600	K1	Brain imaging, ~~limited procedure~~ less than four static views; ~~static~~	XXX	0.44 (No Change)
e▲78601	K2	with vascular flow	XXX	0.51 (No Change)
e▲78605	K3	Brain imaging, ~~complete study~~ minimum four static views; ~~static~~	XXX	0.53 (No Change)
e▲78606	K4	with vascular flow	XXX	0.64 (No Change)
e▲78607	K5	Brain imaging, ~~complete study;~~ tomographic (SPECT)	XXX	1.23 (No Change)
78608		Brain imaging, positron emission tomography (PET); metabolic evaluation	XXX	N/A
78609		Brain imaging, positron emission tomography (PET); perfusion evaluation	XXX	N/A
78610		Brain imaging, vascular flow only	XXX	0.30 (No Change)
D 78615		~~Cerebral vascular flow~~ (78615 has been deleted. To report, see 78610)	XXX	N/A
78630		Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	XXX	0.68 (No Change)

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

PET Imaging

At its February 2007 meeting, the CPT Editorial Panel revised a family of position emission tomography services, 78811-78816, by removing the words "tumor imaging" from the current descriptors. With this change, these services may be reported for other indications, such as for infection. The specialty society purported that the coding change (removing the indication for the procedure) was editorial in nature, consistent with CPT policy, and is in concert with most other codes in the 70000 series. The Panel referred the determination of potential changes to physician work as a result of the descriptor change to the RUC for consideration At the April 2007 RUC meeting, the RUC concluded, based on a review of the coding proposal and the specialty society presentation, that the removal of "tumor imaging" from CPT codes 78811-78816 is editorial in nature and does not require any review of the physician work involved in the service.

The RUC recommends that the current work RVUs be maintained for CPT codes 78811-78816.

New Technology

The services described in CPT codes 78811-78816 do not involve new technology, however, the services do meet the criteria for inclusion on the new technology list because they include established technology used in a new way. **The RUC recommends that codes 78811-78816 be added to the new technology list to review potential changes in valuation after experience in reporting of these services has occurred.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(78810 has been deleted. To report, see 78811-78813)				
(For PET of brain, see 78608, 78609)				
(For PET myocardial imaging, see 78459, 78491, 78492)				

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Manual Microdissection

The CPT Editorial Panel created two new codes to differentiate manual and laser microdissection, which was previously captured in one microdissection code, regardless of the method used.

The RUC reviewed the survey data for codes 88381 *Microdissection (ie, sample preparation of microscopically identified target); manual* and 88380 *Microdissection (ie, sample preparation of microscopically identified target); laser capture* and determined that the median work relative value units and physician times were appropriate. The RUC compared code 88381 to the survey reference code 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (RVU= 1.10, intra-service time = 35 minutes) and determined that the physician work involved, the intensity and complexity, technical skill and physical effort was slightly higher to perform 88381 compared to the reference service. Code 88381 is more intense than the reference service due to the precise dissection of tissue required and the avoidance of contamination with other DNA during dissection. Additionally, the RUC determined that although the intra-service time is slightly lower for 88381 compared to the reference service, the intensity and complexity of the dissection involved in the procedure is higher. The RUC recommends an intra-service time of 30 minutes for code 88381. **The RUC recommends a work RVU of 1.18 for code 88381.**

The RUC compared code 88380 to the survey reference code 88368 *Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; manual* (work RVU=1.40, intra-service time = 45 minutes) and determined that the physician work involved, the intensity and complexity, technical skill and physical effort was slightly higher to perform 88380 compared to the reference service because the laser capture requires more precision than manual microdissection. Additionally, the RUC determined that the survey median intra-service time of 45 minutes is the same as reference code 88368 and is comparably appropriate for code 88380. Although the intra-service times for 88380 and 88368 are identical, the intensity and complexity, mental effort and judgment and technical skill involved to perform the precise dissection of 88380 is higher. Therefore, the RUC recommends a slightly higher work RVU for code 88380. **The RUC recommends a work RVU of 1.56 for code 88380.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Practice Expense

The RUC reviewed the direct practice expense inputs for these codes and made minor modifications to the clinical labor time for the lab tech and histotech, the number of sterile gloves used and equipment utilized. The final direct practice inputs are attached to this recommendation.

New Technology

Codes 88381 and 88380 represent new technology and the RUC agreed that these codes should be placed on the new technology list to review potential changes in its valuation. **The RUC recommends that codes 88381 and 88380 be added to the list of new technology codes.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲88380	L1	Microdissection (~~eg, mechanical, laser capture~~ ie, sample preparation of microscopically identified target); laser capture	XXX	1.56
●88381	L2	manual (Do not report 88380 in conjunction with 88381)	XXX	1.18

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88381 Tracking Number L1 Specialty Society Recommended RVU: **1.18**
Global Period: XXX RUC Recommended RVU: **1.18**

CPT Descriptor: Microdissection (ie, sample preparation of microscopically identified target); manual

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A craniotomy is performed on a 32 year old man with a frontal lobe mass on MRI studies. Two irregular fragments of tissue, (1 x 0.7 x 0.5 and 1.2 x 1.0 x 0.7 cm) are removed, examined grossly, and entirely submitted for fixation and subsequent histologic examination. A diagnosis of glioma is made. Special stains and molecular analysis are requested to resolve tumor classification and guide therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: Following comparison with adjacent stained sections from the same tissue block, areas of glioma are relatively distinct from the background normal brain. The pathologist can separate the tumor from normal-appearing tissue on unstained paraffin sections under a dissecting microscope using a razor blade or scalpel. Tissue from normal and tumor-enriched areas undergo separate DNA preparation and analysis for loss of heterozygosity (LOH) using a panel of simple tandem repeat polymorphic markers directed at specific regions on the short and long arms of chromosomes 1 and 19, respectively. LOH is identified for informative markers in both chromosomal regions tested, indicating a favorable prognosis for this tumor on procarbazine, lomustine, and vincristine therapy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Jonathan L. Myles, MD, Mahesh Mansukhani, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	88381				
Sample Size: 23	**Resp N:** 18	**Response:** 78.2 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	10.00	30.00	**55.00**	100.00	600.00
Survey RVW:	0.24	1.00	**1.18**	1.30	1.70
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	24.25	**30.00**	35.00	40.00
Immediate Post Service-Time:	**0.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			

CPT Code: 88381

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 88381						
		Specialty Recommended				
Physician Work RVU:						
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:						
Immediate Post Service-Time:	____					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x	99292x			
Other Hospital time/visit(s):	0.0	99231x	99232x	99233x		
Discharge Day Mgmt:	0.0	99238x	99239x			
Office time/visit(s):	0.0	99211x	12x	13x	14x	15x
Prolonged Services:	0.0	99354x	55x	56x	57x	

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88360	XXX	1.10	RUC Time

CPT Descriptor Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

88365 XXX 1.20 **RUC Time**

CPT Descriptor In situ hybridization (eg, FISH), each probe

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 44.4 %

TIME ESTIMATES (Median)

	CPT Code: 88381	Key Reference CPT Code: 88360	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	35.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**30.00**	**35.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	3.00
Urgency of medical decision making	3.20	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	3.20
Physical effort required	2.60	1.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.60
Outcome depends on the skill and judgment of physician	4.00	3.40

Estimated risk of malpractice suit with poor outcome	2.60	2.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.40	2.20
Intra-Service intensity/complexity	3.60	3.20
Post-Service intensity/complexity	2.60	2.20

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general and academic pathology community, and members with molecular pathology experience. The relative value workgroup felt that while the range of RVW and time results was symmetrical and internally consistent, producing a supportable median, due to the low response rate, an Expert Panel was required to validate the findings and make official recommendations on the microdissection codes. The Expert Panel included members of CAP's relative value workgroup and the Molecular Pathology Committee. The expert panel was also supplemented by molecular pathologists who actively perform the surveyed service. The panel supported the survey's median RVU of 1.18 based on validity of the internal consistency of the data and the increase in intensity, complexity and technical skill required to perform manual microdissection in comparison to the key reference code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88380

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pathology Frequency 5000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88380 Tracking Number L2 Specialty Society Recommended RVU: **1.56**
Global Period: XXX RUC Recommended RVU: **1.56**

CPT Descriptor: Microdissection (ie, sample preparation of microscopically identified target); laser capture

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A craniotomy is performed on a 32 year old man with a frontal lobe mass on MRI studies. Two irregular fragments of tissue, (1 x 0.7 x 0.5 and 1.2 x 1.0 x 0.7 cm) are removed, examined grossly, and entirely submitted for fixation and subsequent histologic examination. A diagnosis of glioma is made. Special stains and molecular analysis are requested to resolve tumor classification and guide therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: Following comparison with adjacent stained sections from the same tissue block, areas of glioma are infiltrating through normal brain tissue and are nearly inseparable. The pathologist performs laser capture microdissection to individually separate tumor cells from the background brain tissue. Tissue from normal and tumor-enriched areas undergo separate DNA preparation and analysis for loss of heterozygosity (LOH) using a panel of simple tandem repeat polymorphic markers directed at specific regions on the short and long arms of chromosomes 1 and 19, respectively. LOH is identified for informative markers in both chromosomal regions tested, indicating a favorable prognosis for this tumor on procarbazine, lomustine, and vincristine therapy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Jonathan L. Myles, MD, Mahesh Mansukhani, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	88380				
Sample Size: 14	**Resp N:** 11	**Response:** 78.5 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	2.00	10.00	**45.00**	100.00	141.00
Survey RVW:	1.15	1.38	**1.56**	1.80	2.10
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	30.00	42.50	**45.00**	45.00	70.00
Immediate Post Service-Time:	**0.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			

CPT Code: 88380

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 88380	
	Specialty Recommended
Physician Work RVU:	
Pre-Service Evaluation Time:	
Pre-Service Positioning Time:	
Pre-Service Scrub, Dress, Wait Time:	
Intra-Service Time:	

Immediate Post Service-Time:	____					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x	99292x			
Other Hospital time/visit(s):	**0.0**	99231x	99232x	99233x		
Discharge Day Mgmt:	**0.0**	99238x	99239x			
Office time/visit(s):	**0.0**	99211x	12x	13x	14x	15x
Prolonged Services:	**0.0**	99354x	55x	56x	57x	

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88368	XXX	1.40	RUC Time

CPT Descriptor Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; manual

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
88365	XXX	1.20	RUC Time

CPT Descriptor In situ hybridization (eg, FISH), each probe

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 60.0 %

TIME ESTIMATES (Median)

	CPT Code: 88380	Key Reference CPT Code: 88368	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	45.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**45.00**	**45.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.30	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.10
Urgency of medical decision making	3.40	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.70	4.00
Physical effort required	3.60	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.90	2.70
Outcome depends on the skill and judgment of physician	4.30	4.00
Estimated risk of malpractice suit with poor outcome	3.10	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	1.50
Intra-Service intensity/complexity	4.50	4.00
Post-Service intensity/complexity	1.50	1.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general and academic pathology community, and members with molecular pathology experience. The relative value workgroup felt that while the range of RVW and time results was symmetrical and consistent in range, producing a supportable median, due to the low response rate, an Expert Panel was required to validate the findings and make official recommendations on the microdissection codes. The Expert Panel included members of CAP's relative value workgroup and the Molecular Pathology Committee. The expert panel was also supplemented by molecular pathologists who actively perform the surveyed service. The panel supported the survey's median RVU of 1.56 based on validity of the internal consistency of the data and the increase in intensity, complexity and technical skill required to perform laser microdissection in comparison to the key reference code. In addition, on survey data, there is a noteworthy increase in RVW for the 8838X2 of 0.38 with an increase in physician time of 15 minutes over the 8818X1 code.

In comparing the surveyed time between the two codes in this family, the 33% increase would supports an increase in RVW for the 8838X2 of 0.39, for a total of 1.57. This further validates the surveyed median value increase between the two codes in this family of 0.38, for a recommended value of 1.56.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88380

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pathology Frequency 1000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

---

Attestation Statement

CPT Code:_88381, 88380_____

AMTA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

Sample Size:_No Survey_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

CPT Long Descriptor:

88381 Microdissection (ie, sample preparation of microscopically identified target); manual

88380 Microdissection (ie, sample preparation of microscopically identified target); laser capture

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Data were developed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general and academic pathology community, and members with molecular pathology experience. Molecular pathologists who actively perform the services were also consulted during the data development. The collected data were reviewed by a group of 12 pathologists including CAP's relative value workgroup supplemented by pathologists who perform the services. The data were also subject to additional review by another committee of 10 pathologists.

See Excel spreadsheet for labor, supplies and equipment detail.

RUC Recommendation			88381		88380	
Meeting Date: February 2007			Code Descriptor: Microdissection (ie, sample preparation of microscopically identified target); manual		Code Descriptor: Microdissection (ie, sample preparation of microscopically identified target); laser capture	
LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
GLOBAL PERIOD			XXX		XXX	
TOTAL CLINICAL LABOR TIME	LO33A LO37B LO45A	Labtech Histotech Cytotech	106.5		96.5	
SUBTOTAL CLINICAL LABOR PER STAFF TYPE	LO33A	Labtech	17.5		17.5	
SUBTOTAL CLINICAL LABOR PER STAFF TYPE	L037B	Histotech	32		32	
SUBTOTAL CLINICAL LABOR PER STAFF TYPE	LO45A	Cytotech	57		47	
TOTAL PRE-SERV CLINICAL LABOR TIME PER STAFF TYPE	LO33A	Labtech	5.5		5.5	
TOTAL PRE-SERV CLINICAL LABOR TIME PER STAFF TYPE	L037B	Histotech	32		32	
TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF	LO33A	Labtech	4		4	
TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF	L037B	Histotech	0		0	
TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF	LO45A	Cytotech	57		47	
TOTAL POST-SERV CLINICAL LABOR TIME	LO33A	Labtech	8		8	
PRE-SERVICE						
Start: When containers/requisitions prepared for physician						
Prepare specimen containers/preload fixative/label containers/distributre requisition form(s) to physician						
Accession specimen/prepare for examination, assemble slides	LO33A	Labtech	3		3	
Perform screening function (where applicable)						
Prepare room. Filter and replenish stains and supplies.						
Other Clinical Activity (please specify): Retrieve block.	LO33A	Labtech	2.5		2.5	
Process specimen for H&E slide preparation (includes refacing block and preparing for cutting, step sectioning and recuts, routine staining, coverslipping, quality control function, maintaining specimen tracking logs and labeling.)	L037B	Histotech	32		32	
End: When specimen is ready for examination by pathologist						
SERVICE PERIOD						
Start: When specimen is ready for examination by pathologist						
Assemble and deliver slides with paperwork to pathologists for H&E examination and target selection	LO33A	Labtech	2		2	
Slides and paperwork delivered to the laboratory after target selection	L033A	Labtech	2		2	
Deparaffination of unstained slides	LO45A	Cytotech	15		15	
Examination of unstained stains to verify and visualize targets; mark with pen	LO45A	Cytotech	8		8	
Collect and label tubes for target	LO45A	Cytotech	2		2	
Decontamination of workspace and dissecting scope	LO45A	Cytotech	3		0	

RUC Recommendation			88381		88380	
Meeting Date: February 2007			Code Descriptor: Microdissection (ie, sample preparation of microscopically identified target); manual		Code Descriptor: Microdissection (ie, sample preparation of microscopically identified target); laser capture	
LOCATION	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
Prepare Laser instrument, quality control and maintenance functions	LO45A	Cytotech	0		3	
Microdissect each unstained slide sequentially while reviewing H and E stained slide	LO45A	Cytotech	25		15	
Document procedure in logs and place tubes in storage until extraction	LO45A	Cytotech	4		4	
Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)						
Prepare specimen for automated processing						
Process specimen for slide preparation (includes staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)						
Assemble and deliver slides with paperwork to pathologists						
Clean room/equipment whiile performing service						
Coordinate care						
Other Activity (please specify)						
End: When specimen examination by pathologist is complete						
POST-SERVICE Period						
Start: When specimen examination by pathologist is complete						
Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)	LO33A	Labtech	6		6	
Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	LO33A	Labtech	2		2	
Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)						
Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation						
Submit/receive material for consultation (where applicable)						
Other Activity (please specify)						
End: When specimen, chemical waste and record handling is complete						

RUC Recommendation			88381		88380	
Meeting Date: February 2007			Code Descriptor: Microdissection (ie, sample preparation of microscopically identified target); manual		Code Descriptor: Microdissection (ie, sample preparation of microscopically identified target); laser capture	
LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
MEDICAL SUPPLIES	CMS Code	Unit				
gloves, sterile	SB024	pair	4		4	
blade, microtome	SF004	item	2		2	
blade, sharp pointed surgical (VWR* Catalog #80087-010)		item	6		0	
canned air (Dust-Off)	SK097	oz	1		0	
cover slip, glass	SL030	item	2		2	
slide, microscope, sterile (SDL* Catalog #050-S)		item	6		6	
slide, microscope	SL122	item	2		2	
stain, frozen section, H&E (1ml per slide)	SL134	ml	2		2	
xylene solvent	SL151	ml	100		100	
ethanol, 100%	SL189	ml	100		100	
ethanol, 70 %	SL190	ml	100		100	
ethanol, 95% (VWR* Cataog #89015-454)		ml	100		100	
tube, centrifuge, micro, 1.5 ml, DNase free snap lock, sterile	SL240	item	6		6	
Lysis buffer (VWR * Catalog #PAE2661)		ml	50		0	
Rnase-free water (VWR* Catalog #100554-394)		ml	50		0	
CapSure Macro LCM caps (MDC* Catalog #LCM0211)		item	0		2	
methylene blue stain (VWR* Catalog #EM-R03101-74)		ml	0		6	
Glycerol, 3%		ml	100		100	
Equipment	CMS Code					
dissecting microscope	EP023		1		0	
microscope, compound	EP024		1		1	
microtome	ER041		1		1	
Arcturus Veritas Microdissection Instrument (MDC* Catalog #VERITAS)			0		1	
slide etcher-labeler	EP035		1		1	

* VWR = VWR Scientific Products, 3000 Hadley Road, South Plainfield, NJ 07080, (800) 932-5000, www.vwrsp.com
* SDL = Scientific Device Laboratory, 411 East Jarvis Ave., Des Plaines, IL 60018. (847-803-9495). www.scientificdevice.com
* MDC = Molecular Devices Corporation, 1311 Orleans Drive, Sunnyvale, CA 94089-1136. (800-635-5577). www.moleculardevices.com

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Immune Globulin Subcutaneous Infusion

In November 2006, the CPT Editorial Panel created three new codes to provide more specificity to current infusion codes. Current infusion codes describe intravenous routes only. Adding "subcutaneous" as a route of infusion allows for more appropriate coding in the clinical setting. Where patients must be monitored for reaction to the immune globulin when it is first introduced.

90769
The RUC reviewed the specialty society's survey results and recommendations for new CPT code 90769, *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pumping set up and establishment of subcutaneous infusion site(s).* The specialty society's key reference code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU = 0.28) was believed to involve more stress, mental effort, and physician judgment than the surveyed code. The specialty's other reference code, 90765, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21), was deemed more appropriate. The RUC agreed that the work inherent in new code 90769, is primarily supervisory and identical to the work involved in 90765. **The RUC recommends a physician work RVU of 0.21 for code 90769.** (with pre-service time of 5 minutes, intra-service time of 10 minutes, and post-service time of 2 minutes for CPT)

90770
The RUC reviewed the specialty society's survey results and recommendations for new CPT code 90770, *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional (list separately in addition to code for primary procedure) (Report 90770 with 90769) (Report 90770 for infusion intervals of greater than 30 minutes beyond one hour increments.* The RUC agreed that the work inherent in the service is primarily supervisory and identical to the work involved in its key reference service 90766, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)* (work RVU = 0.18). The RUC agreed that code 90770 required an additional two minutes of physician time, but was less intense than 90766. **The RUC recommends a work RVU of 0.18 for code 90770.** (with pre-service time of 0 minutes, intra-service time of 5 minutes, and post-service time of 0 minutes for 90770)

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90771

The specialty society clarified the process of performing CPT 90771, *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment of new subcutaneous infusion site(s) (list separately in addition to 90769) (Report 90771 with 90769) (Report 90769 and 90771 only once per encounter).* After considering the specialty society presentation, the RUC determined that there was no physician work involved in performing the service and should be considered practice expense only. **The RUC recommends that 90771 be valued as practice expense only (work RVU = 0.00).**

New Technology: The RUC recommends this family of codes to be added to the new technology list.

Practice Expense

The RUC reviewed the specialty society's practice expense inputs for this new family of CPT codes. The RUC and the specialty agreed that the codes would typically not be billed with an evaluation and management code and therefore required additional clinical labor time for meeting and greeting the patient and for completing post service medical record documentation. In addition, the RUC agreed that there would be no vital signs taken, and no clinical monitoring for the addition of an infusion pump in code 90771, and the mixture of additional drugs would not require as much time as the first batch and reduced the clinical labor time from 7 minutes to 3. The RUC recommends no practice expense inputs for the facility setting and the following attached direct inputs for the non-facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•90769	SS1	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s) (For infusions of 15 minutes or less use 90772)	XXX	0.21
• +90770	SS2	each additional hour (list separately in addition to code for primary procedure) (Report 90770 with 90769) (Report 90770 for infusion intervals of greater than 30 minutes beyond one hour increments)	ZZZ	0.18
•+90771	SS3	additional pump set up with establishment of new subcutaneous infusion site(s)	ZZZ	0.00 (Practice Expense

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(list separately in addition to 90769) (Report 90771 with 90769) (Report 90769 and 90771 only once per encounter)		Only)

1587

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90769 Tracking Number SS1 Specialty Society Recommended RVU: **0.25**
Global Period: XXX RUC Recommended RVU: **0.21**

CPT Descriptor: Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s). (For infusions of 15 minutes or less use 90772)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 11-year-old 88 lb male with X-linked agammaglobulinemia has been receiving immune globulin replacement therapy on a monthly basis via an indwelling catheter due to vascular access issues. He has been unsuccessful at maintaining an indwelling port without infection.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Separate from an independently reported evaluation and management service, the patient records are reviewed. The physician reviews the transition dosing to SCIg with staff which will involve administration of 35 mls per week into 4 sites to be infused over 1-2 hours depending upon patient tolerability. The physician determines the number of infusion sites. The volume per site is 12 mls and administration is usually completed within a 2 hour time frame. Informed consent is obtained.

Description of Intra-Service Work: Review of vital signs taken by the nurse, up to 4 times per hour. Patient is examined prior to the infusion. Administration of SCIg involves the insertion of subcutaneous catheter(s) into the subcutaneous tissue of the abdomen, upper buttocks, lateral thigh, lateral hip and/or upper arm. The physician supervises the clincal nurse. After initial vital signs taken by the nurse, the physician double checks the dose. The clinician prepares SCIg for infusion using aseptic technique to draw up a syringe. The syringe or medication cassette containing SCIg is then loaded into a syringe driver, roller cassette or infusion pump, infusion rates are set for drug delivery, and tubing is primed. Then, the clinician assesses the site locations and inserts subcutaneous catheter(s), either single site or multi-site sets into the tissue. Catheter placement is checked to insure accurate location of each catheter in the subcutaneous space and not in the vascular space. Catheters are secured and drug is delivered over an average of 1-2 hours. Once completed, infusion is discontinued and waste is properly disposed. The initial set up and first hour of infusion is reported with 907X1. Each additional hour is reported with 907X2. The patient is examined after the infusion is completed. Vital signs are again reviewed, and a general exam is performed.

Description of Post-Service Work: Since reactions to the medication can happen even the next day, during discharge the patient is reminded of what can normally be expected. Whether the patient's infusion is reported with 907X1 alone, or in addition to 907X2 and 907X3, the patient is discharged with instructions to care for infusion sites and to check for any infection in the area. Medical record documentation is completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Donald W. Aaronson, MD, JD, MPH and Charles H. Kirkpatrick, MD		
Specialty(s):	Joint Council of Allergy, Asthma and Immunology (JCAAI) and American Academy of Allergy, Asthma and Immunology (AAAAI)		
CPT Code:	90769		
Sample Size: 100	**Resp N:**	17	**Response:** 17.0 %

CPT Code: 90769

Sample Type: Panel						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	5.00	**15.00**	30.00	180.00
Survey RVW:		0.14	0.20	**0.25**	0.35	1.61
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	15.00	**15.00**	20.00	40.00
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 90769		
		Specialty Recommended
Physician Work RVU:		0.21
Pre-Service Evaluation Time:		5.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		10.00
Immediate Post Service-Time:	2.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96413	XXX	0.28	RUC Time

CPT Descriptor Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99211	XXX	10,302,555	0.17	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99213	XXX	111,146,496	0.92	RUC Time

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem

focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
90765	XXX	0.21	**RUC Time**

CPT Descriptor Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial up to one hour

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 35.2 %

TIME ESTIMATES (Median)	CPT Code: 90769	Key Reference CPT Code: 96413	Source of Time RUC Time
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	10.00	7.00	
Median Immediate Post-service Time	2.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**17.00**	**13.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.87	4.00
Urgency of medical decision making	3.13	2.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.29	3.00
Physical effort required	2.71	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.53	3.83
Outcome depends on the skill and judgment of physician	3.88	4.50
Estimated risk of malpractice suit with poor outcome	3.18	3.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.41	3.50
Intra-Service intensity/complexity	2.76	2.17
Post-Service intensity/complexity	2.59	2.17

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
JCAAI distributed 92 survey links to members of the Primary Immune Deficiency Committee of the Academy three times and had contacted the company and had 18 names of physicians who had purchased the SubQ product and contacted them via email and a phone message asking them to participate in the survey. The consensus conference call was held on March 27 and these results are presented from the deliberations of the conference call. Note that industry requested this code for a product just coming to market and we are quite pleased with getting 17 responses, and are short of the 30 required. We thereby request Pre-Facilitation to review this data.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and

accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. SEE LAST PAGE

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) new product

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Allergy/Immunology How often? Sometimes

Specialty Infectious Disease How often? Sometimes

Specialty Oncology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. 360 payers recognize this procedure; with 1300 patients being infused, and most already self-administering the infusions; about 60-70 patients are new to infusions per month

Specialty Allergy/Immunology Frequency 1050 Percentage 70.00 %

Specialty Infectious Disease Frequency 225 Percentage 15.00 %

Specialty Oncology Frequency 225 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 750
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. about half of the patients infused are Medicare patients

Specialty Allergy/Immunology Frequency 525 Percentage 70.00 %

Specialty Infectious Disease Frequency 112 Percentage 14.93 %

Specialty Oncology Frequency 112.5 Percentage 0.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 90765

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

CPT Code	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	IWPUT
90769	5	10	2	17	0.25	0.009
99213	3	15	5	23	0.92	0.049

Code: 90769

99214	**5**	**25**	**10**	**40**	**1.42**	**0.043**
99215	**5**	**35**	**15**	**55**	**2.00**	**0.044**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90770 Tracking Number SS2 Specialty Society Recommended RVU: **0.19**
Global Period: ZZZ RUC Recommended RVU: **0.18**

CPT Descriptor: Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure) (Report 907X2 with 907X1) (Report 907X2 for infusion intervals of greater than 30 minutes beyond one hour increments)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47 year-old 154 lb male presents with a 5-year history of Common Variable Immunodeficiency and recurrent pneumonia. He has had severe myalgia and migraine headache disability for 3 days post each IVIg infusion. Due to tolerability issues with IVIg, he elects to switch SCIg.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: NONE

Description of Intra-Service Work: the additional hour of infusion; vital signs reviewed

Description of Post-Service Work: NONE

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Donald W. Aaronson, MD, JD, MPH and Charles H. Kirkpatrick, MD					
Specialty(s):	Joint Council of Allergy, Asthma and Immunology (JCAAI) and American Academy of Allergy, Asthma and Immunology (AAAAI)					
CPT Code:	90770					
Sample Size:	100	**Resp N:** 17	**Response:** 17.0 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	4.00	**10.00**	40.00	160.00
Survey RVW:		0.10	0.18	**0.19**	0.21	0.50
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	5.00	**10.00**	15.00	20.00
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				

CPT Code: 90770

Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 90770		
		Specialty Recommended
Physician Work RVU:		0.18
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		5.00
Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90766	ZZZ	0.18	RUC Time

CPT Descriptor Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99211	XXX	10,302,555	0.17	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
13102	ZZZ	10,782	1.24	RUC Time

CPT Descriptor 2 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
96415	ZZZ	0.19	**RUC Time**

CPT Descriptor Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 29.4 %

TIME ESTIMATES (Median)	CPT Code: 90770	Key Reference CPT Code: 90766	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	5.00	3.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**5.00**	**3.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	3.20
Urgency of medical decision making	2.57	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.71	3.40
Physical effort required	2.29	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.76	3.20
Outcome depends on the skill and judgment of physician	3.00	3.40
Estimated risk of malpractice suit with poor outcome	2.65	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.24	2.40
Post-Service intensity/complexity		

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See 907X1

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This add-on ZZZ code is reported with 907X1

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) new product

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Allergy/Immunology How often? Sometimes

Specialty Infectious Disease How often? Sometimes

Specialty Oncology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. this is less frequent that 907X1

Specialty Allergy/Immunology Frequency 700 Percentage 70.00 %

Specialty Infectious Disease Frequency 150 Percentage 15.00 %

Specialty Oncology Frequency 150 Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Allergy/Immunology Frequency 560 Percentage 70.00 %

Specialty Infectious Disease Frequency 120 Percentage 15.00 %

Specialty Oncology Frequency 120 Percentage 15.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

CPT Code	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	IWPUT
90769	5	10	2	17	0.25	0.009
90770	0	5	0	5	0.19	0.023
99213	3	15	5	23	0.92	0.049
99214	5	25	10	40	1.42	0.043
99215	5	35	15	55	2.00	0.044

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **90769** Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s). (For infusions of 15 minutes or less use 90772)
90770 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure) (Report 90770 with 90769) (Report 90770 for infusion intervals of greater than 30 minutes beyond one hour increments)
90771 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment of new subcutaneous infusion site(s) (List separately in additional to 90769) (Report 90771 with 90769) (Report 90769 and X3 only once per encounter)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Joint Council of Allergy, Asthma and Immunology (JCAAI) and the American Academy of Allergy, Asthma and Immunology have provided the practice expense documents for review at the April 25, 2007 PERC meeting for review. The Primary Immune Deficiency Committee met on March 27 to review the RUC survey data as well as to come to consensus on the practice expense clinical staff, medical supplies and equipment inputs. The committee was representative of practice type, geographic location and represented adult and pediatric allergists.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Remove medication from the refrigerator one hour prior to the infusion
- Dosing is based on patient weight and dosage determined for insurance authorization
- Review the physician orders and plan for infusion
- Gather equipment and supplies and double checking the dosing requirements
- Utilizing aseptic technique, prepare the medication, drawing into a syringe and/or loading into the pump
- Set up the infusion pump, insert the cassette and two AA batteries
- Program the infusion pump
- Connect all tubings and for multiple infusions, connect the y-site tubing, keep clamp closed on cassette tubing
- Prime all tubings so that they are free of air
- Wash Hands
- Nurse reinforces the previous explanation by the physician and reviews procedure and prepares the patient again for the infusion experience.

Intra-Service Clinical Labor Activities:

- Vital signs taken at least four times on new patients for the first hour to assess medication tolerance
- About 15 minutes before insertion, apply Emla cream to numb the site(s), if needed
- Inspect sites prior to catheter insertion

- Insert the subcutaneous catheters into 2-4 sites on the abdomen, upper buttocks, lateral thigh, lateral hip or upper arms (average is 4 for adults and 2 for children)
- Wash hands, and cleanse the skin first with alcohol and then betadine
- Nurse talks with the patient through many of these procedures to clinically monitor patient wellbeing, asking questions such as are they feeling warm, itchy, problems breathing, feeling flushed, any pain at the infusion sites, and reviews again the procedure with the patient and caregiver, if present
- Check that the catheter is seated properly before insertion
- Ensure that the catheter is not in a vein and is in subcutaneous tissue by verifying no blood return. For each infusion site, attach a sterile syringe to the end of the primed administration tubing or catheter. If blood flows back into the tubing, discard the needle and tubing and change site(s) and repeat process.
- Slide the needle out of the catheter
- Apply the transparent dressing
- Recheck pump settings and open all clamps
- Turn on the pump
- Monitor the patient
- After completion of each infusion, turn off the pump and remove the catheters
- Massage the site for approximately 1 minute after removing the subcutaneous catheter
- Apply a dressing to the site(s)
- Remove the batteries and cassette from the pump

Post-Service Clinical Labor Activities:

- The nurse restates the physician's instructions on what to expect regarding common reactions at the site: minor swelling and redness, localized rash and/or minor burning, minor irritation/soreness, and minor hardness
- Set up appointment for next infusion
- Ongoing education to demonstrate to the patient and caregiver the procedure in the event that they would eventually be able to self-administer the infusion
- The nurse reviews all discharge orders and answers any questions

	A	B	C	D	E	F	G	H	I
1				90769		90770		90771	
2	AMA/Specialty Society RVS Update Committee Recommendation			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set up and establishment of subcutaneous infusion site(s). (For infusions of 15 minutes or less use 90772)		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure) (Report 90770 with 90769) (Report 90770 for infusion intervals of greater than 30 minutes beyond one hour increments)		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment o new subcutaneous infusion site(s) (List separately in additional to 90769) (Report 90771 with 90769) (Report 90769 and 90771 only once per encounter)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ
5	TOTAL CLINICAL LABOR TIME	L051A	RN	48.0	0.0	10.0	0.0	7.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	6.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	41.0	0.0	10.0	0.0	7.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	1.0	0.0	0.0	0.0	0.0	0.0
9	PRE-SERVICE								
10	Start: Following visit when decision for surgery or procedure made								
11	Complete pre-service diagnostic & referral forms		RN	3					
12	Coordinate pre-surgery services	L051A	RN	3					
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	End:When patient enters office/facility for surgery/procedure								
18	SERVICE PERIOD								
19	Start: When patient enters office/facility for surgery/procedure								
20	Pre-service services								
21	Review charts by nurse regarding course of treatment and obtain history	L051A	RN						
22	Greet patient and provide gowning	L051A	RN	2					
23	Obtain vital signs	L051A	RN	3		3			
24	Provide pre-service education/obtain consent		RN	3					
25	Prepare room, equipment, supplies	L051A	RN	2				2	
26	Mix drug and prepare for titration	L051A	RN	7				3	
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L051A	RN	2				2	
29	Sedate/apply anesthesia								
30	Intra-service								
31	Assist physician in performing procedure								
32	Initiation of the infusion including clinical assessment	L051A	RN	5					
33	Clinical monitoring during the infusion	L051A	RN	7		7			
34	Post-Service								
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	2					
36	Discontinuation of infusion and patient education	L051A	RN	2					
37	Clean room/equipment by physician staff	L051A	RN	3					
38	Clean Scope								
39	Clean Surgical Instrument Package								
40	Complete diagnostic forms, lab & X-ray requisitions								
41	Complete medical record documentation								
42	Review/read X-ray, lab, and pathology reports								
43	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN	3					
44	Typically there are 4 sites for 907X1/2 and 2 sites for 907X3.								
45	End: Patient leaves office								
46	POST-SERVICE								
47	Start: Patient leaves office/facility			No Post Service Period Direct Inputs					

1605

	A	B	C	D	E	F	G	H	I
1				90769		90770		90771	
2	AMA/Specialty Society RVS Update Committee Recommendation			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pump set up and establishment of subcutaneous infusion site(s). (For infusions of 15 minutes or less use 90772)		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure) (Report 90770 with 90769) (Report 90770 for infusion intervals of greater than 30 minutes beyond one hour increments)		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment o new subcutaneous infusion site(s) (List separately in additional to 90769). (Report 90771 with 90769) (Report 90769 and 90771 only once per encounter)	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
55	[illegible]	[illegible]	[illegible]						
56	pack, minimum multi-specialty visit	SA048	1 pack	1					
57	gloves, non-sterile	SB022	Pair					1	
58	infusion pump cassette reservoir	SC013	item	2				1	
59	syringe, 50-60 ml	SC056	item	1				1	
60	syringe w-needle, OSHA compliant (Safety Glide)	SC058	item	2				1	
61	needle, OSHA compliant (Safety Glide)	SC080	item	1				1	
62	tubing, subcutaneous, Y-type	SC087	item	1				1	
63	bandage, strip 0.75in x 3in	SG021	item	1					
64	dressing, 4 in x 4.75 (Tegaderm)	SG037	item	3				1	
65	gauze, non-sterile 2in x 2in	SG050	pad	2				1	
66	tape, elastic, 1 inch	SG075	inch	4				2	
67	Emla cream	SH030	gram	1				1	
68	saline		ounces	1				1	
69	povidone soln (Betadine)	SJ041	ml	2					
70	swab-pad, alcohol	SJ053	Box of 10	1					
71	cup, drinking	SK018	item	1					
72	graham crackers, 1 packet	SK040	item	1					
73	juice, apple, 1 oz	SK042	Ounces	6					
74	battery, AA	SK095	item	2				1	
75	disinfectatnt, surface (Envirocide, Sanicide)	SM013	Ounces	10ml				10ml	
76	Sof-set Ultimate Infusion Set $138 MiniMed emailed CMS catalogue on 032907		item	4				2	
77									
78									
79	[illegible]	[illegible]	[illegible]						
80	infusion pump (Cadd Legacy - $2500)			1					
81	exam table	E1001		1					

1606

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Insertion and Placement of Heart Catheter

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they determined should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 93503 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 93503 to the RUC. Code 93503 had never been surveyed nor discussed at the RUC previously. The RUC understands that it is tasked with considering whether 93503 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 93503.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post-service periods which would disqualify 93503 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

After significant discussion, the RUC determined that specialty society recommended pre-service time did not accurately reflect the service and decreased it from 20 minutes to 12 minutes, while retaining the post-operative time at 10 minutes. **Due to this detailed review of the pre-service and post-service time to ensure no duplication with other services reported on the same date, the RUC recommends that 93503 be retained on the Modifier -51 Exempt List.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The specialty reviewed the survey results for this procedure and determined that the survey results support the existing value of the code at 2.91 work RVUs. The current value of the code, falls very close to the survey median of 3.00 RVUs. In addition, as the surveyed code's intensity and complexity measures are higher than that of the reference code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (Work RVU=2.50), the current value was believed to be appropriate. **Therefore, the RUC recommends that the new times, 12 minutes of pre-service time, 15 minutes of intra-service time and 10 minutes of post-service time, be associated with 93503 and that the existing value of 2.91 work RVUs be retained for this procedure.**

Practice Expense:
The RUC recommends that the practice expense inputs be retained for this procedure, which is zero PE direct inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲⊘93503	DD4	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	000	2.91 (No Change)

1608

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93503 Tracking Number DD4 Specialty Society Recommended RVU: **2.91**
Global Period: 000 RUC Recommended RVU: **2.91**

CPT Descriptor: Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old man with coronary artery disease following failure of lithotripsy to relieve ureteral obstruction from a stone develops circulatory failure. A pulmonary artery catheter is inserted to guide therapy secondary to urosepsis. He is hypotensive and exhibiting difficulty breathing

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 44%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service includes: a review of records; lab and diagnostic tests; communication with other professionals; patient and family; scrubbing and preparing the patient; instruments and supplies for the procedure; and positioning the patient for the procedure, which is often difficult due to the unstable nature of the patient. Assessment of antibiotic administration status is made and interventions ordered if needed.

Description of Intra-Service Work: A flow-directed pulmonary artery catheter (PA catheter) is typically introduced percutaneously either into the internal jugular vein or subclavian vein. A large bore introducing catheter is first placed into the vein. Then the PA catheter is sterilely inserted through the introducer. The tip of the catheter is passed down through the right atrium and right ventricle and into the pulmonary artery, sometimes with the use of fluoroscopy for direction (separately reportable). On the tip of the catheter is a balloon, which when inflated will occlude the pulmonary artery. The balloon is inflated during passage of the catheter through the heart. The interaction between right heart blood flow and the resistance created by the balloon facilitates passage of the catheter into the pulmonary artery. As the catheter tip passes through the heart into the lungs, it measures the pressures within the cardiac chambers and pulmonary artery. When the balloon is inflated and occludes the pulmonary artery an estimate of left ventricular end-diastolic pressure (LVEDP)is obtained. LVEDP correlates with preload, an important factor in determining adequacy of intravascular volume status. In addition, the PA catheter helps facilitate measurement of intermittent or continuous cardiac output, typically using a thermodilution technique. Some catheters also allow continuous measurement of mixed venous oxygen saturation (SvO2). Changes in SvO2 may indicate changes in oxygen supply/demand balance, a particularly important factor in the critically ill.

Description of Post-Service Work: Post-service work and time is significantly greater with the PA catheter as the catheter is likely to remain in place in the patient for five days as compared to at the most 1-2 hours for the right heart catheter Because the PA catheter remains in place considerably longer, there is a significantly increased risk of sepsis, venous thrombosis and pulmonary infarction. A procedure note is written in the chart as are any orders including obtaining a chest X-ray for placement and to rule out initial placement complications such as pneumothorax.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Tripti Kataria, MD, MPH		
Specialty(s):	American Society of Anesthesiologists		
CPT Code:	93503		
Sample Size: 250	**Resp N:** 41	**Response:** 16.4 %	

Sample Type: Panel						
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	4.00	**10.00**	40.00	100.00
Survey RVW:		1.55	2.75	**3.00**	3.50	13.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		2.00	15.00	**15.00**	25.00	45.00
Immediate Post Service-Time:	10.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 93503		
		Specialty Recommended
Physician Work RVU:		2.91
Pre-Service Evaluation Time:		5.0
Pre-Service Positioning Time:		2.0
Pre-Service Scrub, Dress, Wait Time:		5.0
Intra-Service Time:		15.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93508	000	93,567	4.09	RUC Time

CPT Descriptor 1 Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization

(note: on Appendix G - Moderate Sedation)

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
36556	000	654,136	2.50	RUC Time

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 68.2 %

TIME ESTIMATES (Median)

	CPT Code: 93503	Key Reference CPT Code: 36556	Source of Time RUC Time
Median Pre-Service Time	12.00	25.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**37.00**	**50.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.04
Urgency of medical decision making	3.93	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	4.39	3.54
Physical effort required	3.57	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	3.54
Outcome depends on the skill and judgment of physician	4.39	3.54

Estimated risk of malpractice suit with poor outcome	4.07	3.43

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.54	2.93
Intra-Service intensity/complexity	4.36	3.39
Post-Service intensity/complexity	3.57	2.79

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code comes to the RUC as a result of the CPT review of codes listed in Appendix E – Summary of Codes Exempt from Modifier 51. The Panel agreed that the code met the criteria to remain in this appendix.

While 44% of our respondents indicated that moderate sedation was typical for this procedure, we maintain that it is not inherent to the procedure. Patients may receive "light sedation" and our respondents may have been confused about all the elements inherent in moderate sedation.

The RVUw from the survey indicate that the code is properly valued. The current RVUw is 2.91 which falls very near to our survey median of 3.00. Its complexity/intensity measures are higher than that of the reference code of 36556 with 2.50 work RVUs. We therefore recommend that the code retain its current value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) As a code that is included in CPT Appendix E, it may be reported as a stand alone procedure but is typically adjunctive. We estimate that it is adjunctive 85% of the time.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
Anesthesioloigsts perform this most frequently in conjunction with an anesthesia service (00100-01999). Per CMS and CPT, placement of invasive monitoring devices is separate and distinct from an anesthesia service.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93503

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesia	How often? Commonly
Specialty Cardiology	How often? Sometimes
Specialty Pulmonary Disease	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 791484
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Using the breakdown on file for the Medicare population

Specialty Anestehsia	Frequency 656062	Percentage 82.89 %
Specialty Cardiology	Frequency 35459	Percentage 4.48 %
Specialty Pulmonary Disease	Frequency 23587	Percentage 2.98 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 197,871 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This Medicare frequency information is taken from the RUC database

Specialty Anesthesia	Frequency 164035	Percentage 82.89 %
Specialty Cardiology	Frequency 8865	Percentage 4.48 %
Specialty Pulmonary Disease	Frequency 5897	Percentage 2.98 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. The RUC recommends the current PLI for 93503 be retained

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor: **93503 – Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Anesthesiologists conducted a RUC survey for code 93503 – Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes. The practice expense units were deemed to be unchanged and we recommend keeping the current inputs of zero clinical labor, no supplies and no equipment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

none

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

none

AMA/Specialty Society Update Process
PERC Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **93503 – Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American Society of Anesthesiologists conducted a RUC survey for code 93503 – Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes. The practice expense units were deemed to be unchanged and we recommend keeping the current inputs of zero clinical labor, no supplies and no equipment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1							
2				CPT Code - 93503		CPT Code	
3	Meeting Date: April 2007			Code Descriptor - Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes		Code Descriptor	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			0	0		
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	SERVICE PERIOD						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	**Intra-service**						
31	Assist physician in performing procedure						
32	**Post-Service**						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 –12 minutes 99239 –15 minutes						
41	Other Clinical Activity (please specify)						
42	**End: Patient leaves office**						
43	POST-SERVICE Period						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions						
46	*Office visits:* Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54							
55	*Total Office Visit Time*			0	0	0	0
56	Other Activity (please specify)						
57	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
2				CPT Code - 93503		CPT Code	
3	Meeting Date: April 2007			Code Descriptor - Insertion and placement of flow directed catheter (eg, Swan Ganz) for monitoring purposes		Code Descriptor	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES	CMS Code	Staff Type				
59	No Supplies	SX007					
60							
61							
62							
63							
64							
65							
66	EQUIPMENT	CMS Code	Staff Type				
67	No Equipment	EZ007					
68							
69							

AMA/Specialty Society RVS Update Committee
Five Year Review - Summary of Recommendations

February 2007

Allergy Test Interpretation

At the 2005 Five Year Review, the Joint Council of Allergy, Asthma & Immunology commented that there is physician work involved in allergy test interpretation services that is not being recognized and not reimbursed through any other codes. The specialty society came to the RUC 2005 Five Year Review and presented physician work values for these allergy codes. At the meeting, the specialty presented each code with physician work representing staff supervision and the interpretation of the tests results. The codes are typically billed with an E/M service which, according to CPT, the "actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services." The RUC, at the time could not value the codes based upon the CPT descriptor and the survey results and referred the specialty to the CPT Editorial Panel for clarification and possible revision of the codes to include physician work. In February 2006, the CPT Editorial Panel made modifications to these allergy testing codes in order to include the test interpretation and report provided by a physician (pending RUC survey which would prove that physician work was associated with these services).

For the February 2007 RUC meeting, the specialty surveyed over 100 physicians and provided new survey data with "test interpretation and report by a physician" included in the descriptors. The survey respondents indicated that there is physician work in the three services. The RUC believed that there is physician work in these allergy services and understood that the surveys were based on a battery of tests that are typically performed. The physician work and time is computed to be a small fraction of the surveyed results based on the total service. The survey for CPT code 95004 *Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests* was based on a battery of 40 tests; 95024 *Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests* was based on a battery of 12 tests, and 95027 *Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests* was based on a battery of 45 tests. Surveyed physician time and work was then divided by these typical number of tests and modified for the typical patient encounter.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Physician work for these services were compared to the level two office visit code 99212 (work RVU = 0.45) for time and intensity comparisons based on the three batteries of tests. The RUC believed that this "battery of tests" comparison with the Evaluation and Management codes was valid and established relativity between code families. In addition, the RUC and the specialty agreed that code 95024 was typically billed subsequent to 95004 and thus there would be some overlap in physician time. The RUC therefore agreed that there would be zero pre-service time for 95024 and the post service physician time for code 95004 should more appropriately be 5 minutes, rather than 10 from the survey results with the battery of 40 tests. The RUC agreed that although physician work for each of the single tests was minimal, as a battery of tests, the rank order between each of the codes and the relativity with Evaluation and Management codes is established when the work RVUs are all equal to 0.01. The below chart shows the rank order and relativity based on the battery of tests.

CPT Code	Work RVU	Number of Tests	Work RVU for Battery of Tests
95004	**0.01**	40	0.40
95024	**0.01**	12	0.12
95027	**0.01**	45	0.45
99212	0.45		0.45

The RUC recommends work relative values of 0.01 for revised CPT codes 95004, 95024, and 95027.

Practice Expense

The RUC agreed that the existing practice expense inputs that were reviewed in September 2002 were inappropriate and needed to be revised now that the code values were now based on a number of tests rather than on the number of antigens. The RUC reviewed and revised practice expense inputs based on the following batteries of tests; 95002 – 40 tests, 95024 – 12 tests, and 95027 – 45 tests. The RUC eliminated overlapping clinical labor time among the code set and altered the medical supplies and equipment to reflect the number of tests for each allergy code. The RUC agreed that these revisions now reflected the resources used during the typical patient encounter.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	February 2007 Work RVU Recommendation
~~**Allergy sensitivity tests** describe the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgement. All patients should not necessarily receive the same tests nor the same number of sensitivity tests.~~ ***Immunotherapy (desensitization, hyposensitization)*** *is the parenteral administration . . .* ***Other therapy:*** *for medical conferences on the use of mechanical . . .*				
95004		Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.01
95024		Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.01
95027		Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.01

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:95004 Tracking Number YY1 Specialty Society Recommended RVU: **0.01**
Global Period: XXX RUC Recommended RVU: **0.01**

CPT Descriptor: Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

The numbers reflected below are for a battery of tests in order to allow comparison with the reference codes; data for a single test can be found in the Table in the compelling evidence section.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year old patient reports increased difficulty with head congestion, sneezing and watery eyes with recurrent episodes of wheezing and coughing that are interfering with his work. The patient is seen on referral from his primary care physician. The specialist orders 40 percutaneous skin tests to determine causes and possible therapies.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician instructs the staff as to which allergens to test for and at what concentrations based on the patient's history, symptoms, and environmental/lifestyle factors.

Description of Intra-Service Work: The physician examines and interprets the nature and extent of the patient's reaction including the size of the erythema and wheal and evaluates the controls in comparison to the test allergens to determine if the test is negative or positive (and if positive, the level of positivity).

Description of Post-Service Work: The physician synthesizes the test results and prepares, reviews and signs the report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Donald Aaronson, MD, JCAAI and Paul Fass, MD, AAOA				
Specialty(s):	Joint Council of Allergy, Asthma, and Immunology (JCAAI) and American Academy of Otolargyngic Allergy (AAOA)				
CPT Code:	95004				
Sample Size: 150	**Resp N:** 80	**Response:** 53.3 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	50.00	**175.00**	500.00	3300.00
Survey RVW:	0.11	0.40	**0.70**	0.95	3.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.00	3.00	**5.0**	10.00	45.00

Immediate Post Service-Time:	5.0	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.00 99239x 0.00
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the key reference service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 95004		
		Specialty Recommended
Physician Work RVU:		0.01
Pre-Service Evaluation Time:		0.125
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		0.125
Immediate Post Service-Time:	0.125	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.92	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99212	XXX	26,139,270	0.45	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,552,729	0.92	RUC Time

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

Other Reference CPT Code	Global	Work RVU	Time Source
99212	XXX	0.45	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 21.2 %

TIME ESTIMATES (Median)	CPT Code: 95004	Key Reference CPT Code: 99213	Source of Time RUC Time
Median Pre-Service Time	0.125	3.00	
Median Intra-Service Time	0.125	15.00	
Median Immediate Post-service Time	0.125	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**0.375**	**23.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.43	2.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.58	2.82
Urgency of medical decision making	3.21	2.91
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.07	2.97
Physical effort required	3.31	3.11
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.55	2.83

Outcome depends on the skill and judgment of physician	2.91	2.62
Estimated risk of malpractice suit with poor outcome	2.11	2.22

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.72	2.27
Intra-Service intensity/complexity	3.39	3.09
Post-Service intensity/complexity	3.00	2.66

COMPELLING EVIDENCE RATIONALE (Required to be Completed)
Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

JCAAI and AAOA worked together on this survey including developing a common reference set. This code is valued on a per test basis and typically 40 tests are performed. Because of the difficulty of valuing the work and time of a single test, the Research Subcommittee agreed that we could survey this service based on the performance of the full battery of tests. For the battery of 40 tests, the median work value was 0.70 with total time of 20 minutes. Prorating the median work value on a per test basis, results in a work value of 0.02 per test (rounded). This is the value we are recommending.

The table below shows the RVW and time for both the battery of tests and a single test.

95004	Low	25th pctl	Median	75th pctl	High
95004 per test	0.002	0.01	0.02	0.02	0.08
95004 Typical Patient (40 tests)	0.11	0.45	0.70	0.95	3.00
Intra-Service TIME					
95004 per test	0	0.075	0.13	0.25	1.13
95004 Typical Patient (40 tests)	0	3.00	5.00	10.00	45.00

The remainder of our discussion of the rationale for the recommended value is based on the value for a typical battery of tests which is consistent with survey methodology and which we think is easier to grasp.

We believe that a work value of 0.70 for 40 tests is reasonable and supported by the survey data. The most typically selected reference code was code 99213 which has a work value of 0.92 for total time of 23 minutes compared to a work value of 0.70 for total time of 20 minutes. The survey respondents generally considered this code to be more intense/complex than the reference code. Thus, for a service considered more complex and involving only 10 percent or so less total time, the recommended work value is about 25 percent lower.

There are no codes on the MPC list which are in the same family as allergy testing. We therefore considered other codes on the MPC which have XXX global period status-Code 99212 and Code 93307. Code 99212 has an RVW of 0.45 with total time of 16 minutes. The median survey time for Code 95004 was 20 minutes or 25 percent higher. Given the fact that the surveyed code is considered more complex and intense than Code 99213 (the reference code), it stands to reason that the surveyed code is even more complex than Code 99212. Code 93307 has a work value of

0.92 for 28 minutes of total time. Thus, the recommended work value is about 25 percent less and the total time is proportionately less--about 29 percent less.

Finally, we also looked at the values and times assigned to a commonly performed x-ray procedure on the MPC, Code 71020. This code has a work value of 0.22 and total time of 5 minutes. The surveyed code involves 20 minutes of physician time so that adjusting for the 4-fold time difference, the recommended value of 0.70 is actually proportionately less. In our judgment, interpreting 40 subcutaneous allergy tests is certainly as complex or more complex than interpreting a chest x-ray. Given the 4-fold difference in the time-20 minutes vs. 5 minutes-we would consider the recommended value of 0.70 for the battery of tests reasonable in relationship to this commonly performed x-ray procedure.

In summary we believe the recommended work value is supported by survey data, by comparison to the reference code, two MPC codes and the x-ray procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree
B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:95024 Tracking Number YY2 Specialty Society Recommended RVU: **0.01**
Global Period: XXX RUC Recommended RVU: **0.01**

CPT Descriptor: Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

The numbers reflected below are for a battery of tests in order to allow comparison with the reference codes; data for a single test can be found in the Table in the compelling evidence section.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year old patient reports increased difficulty with head congestion, sneezing and watery eyes with recurrent episodes of wheezing and coughing that are interfering with his work. The patient is seen on referral from his primary care physician. The specialist orders 12 intradermal skin tests to determine causes and possible therapies.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician instructs the staff as to which allergens to test for and at what concentrations based on the patient's history, symptoms, and environmental/lifestyle factors.

Description of Intra-Service Work: The physician examines and interprets the nature and extent of the patient's reaction including the size of the erythema and wheal and evaluates the controls in comparison to the test allergens to determine if the test is negative or positive (and if positive, the level of positivity).

Description of Post-Service Work: The physician synthesizes the test results and prepares, reviews and signs the report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Donald Aaronson, MD, JCAAI and Paul Fass, MD, AAOA				
Specialty(s):	Joint Council of Allergy, Asthma, and Immunology (JCAAI) and American Academy of Otolargyngic Allergy (AAOA)				
CPT Code:	95024				
Sample Size: 150	**Resp N:** 68	**Response:** 45.3 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	50.00	**100.00**	349.00	1800.00
Survey RVW:	0.09	0.49	**0.87**	1.00	4.50
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.00	3.00	**5.0**	10.00	60.00

Immediate Post Service-Time:	10.0	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.00 99239x 0.00
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the key reference service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 95024		
		Specialty Recommended
Physician Work RVU:		0.01
Pre-Service Evaluation Time:		0.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		0.416
Immediate Post Service-Time:	0.833	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.92	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99212	XXX	26,139,270	0.45	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,552,729	0.92	RUC Time

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

Other Reference CPT Code	Global	Work RVU	Time Source
99212	XXX	0.45	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 20.5 %

TIME ESTIMATES (Median)	CPT Code: 95024	Key Reference CPT Code: 99213	Source of Time RUC Time
Median Pre-Service Time	0.000	3.00	
Median Intra-Service Time	0.416	15.00	
Median Immediate Post-service Time	0.833	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**1.249**	**23.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.49	2.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.75
Urgency of medical decision making	3.17	2.82
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.98	2.96
Physical effort required	3.31	2.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.70	2.73

Outcome depends on the skill and judgment of physician	3.39	2.83
Estimated risk of malpractice suit with poor outcome	2.22	2.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.41	2.57
Intra-Service intensity/complexity	3.63	3.14
Post-Service intensity/complexity	3.36	2.70

COMPELLING EVIDENCE RATIONALE (Required to be Completed)
Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

JCAAI and AAOA worked together on this survey including developing a common reference set. This code is valued on a per test basis and typically 12 tests are performed. Because of the difficulty of valuing the work and time of a single test, the Research Subcommittee agreed that we could survey this service for the full battery of tests. For the battery of 12 tests, the median work value recommended was 0.87 with total time of 20 minutes. Prorating the median work value on a per test basis, results in a median work value of 0.07 per test (rounded). However, we are recommending an RVW of 0.04 which is the value represented at the 25th percentile. We think this value provides the correct rank order relationship to Code 95004. While Code 95024 is more complex than Code 95004 and takes additional time per test, we do not think this code should be valued at almost 4 times the value per test of code 95004, which we are recommending be valued at 0.02. We recommend, however, using the survey median time values since these are consistent with the time estimates for 95004 and 95027 and are, we believe, more accurate estimates of the time involved.

The remainder of our discussion of the rationale for the recommended value is based on the value for a typical battery of tests which is consistent with survey methodology and which we think is easier to grasp.

The table below shows the RVW and time for both the battery of tests and a single test.

95024	Low	25th pctl	Median	75th pctl	High
95024 per test	0.008	0.04	0.07	0.08	0.38
95024 Typical Patient (12 tests)	0.09	0.49	0.87	1.00	4.50
Intra-Service TIME					
95024 per test	0	0.03	0.42	0.83	5.00
95024 Typical Patient (12 tests)	0	3.00	5.00	10.00	60.00

The most typically selected reference code was code 99213 which has a work value of 0.92 for total time of 23 minutes. The survey respondents estimated this code to be somewhat more intense/complex than the reference code and the median total time of 20 minutes as slightly lower than the reference code. Our recommended RVW of 0.49 for the full battery of tests is about half of the RVW assigned to the reference code. While a higher RVW might be

justified, based on the median survey response, we believe using the 25th percentile is more appropriate because it more closely reflects the relative relationship of this code to 95004 and to 95027. Thus, in relationship to the reference code, we would consider the recommended value of 0.49 or 0.04 per test certainly reasonable.

There are no codes on the MPC list which are in the same family as allergy testing. We therefore considered other codes on the MPC list which have XXX global period status-Code 99212 and Code 93307. Code 99212 has an RVW of 0.45 with total time of 16 minutes. The survey time for Code 95024 is 20 minutes. However, given the fact that the surveyed code is considered more complex and intense than Code 99213 (the reference code), it stands to reason that the surveyed code is even more complex than Code 99212.

Code 93307 has a work value of 0.92 for 28 minutes of total time. Thus, the recommended work value is about 50 percent of this code while the total time is only about 30 percent less.

Finally, we also looked at the values and times assigned to a commonly performed x-ray procedure on the MPC, Code 71020. This code has a work value of 0.22 and total time of 5 minutes. In our judgment, interpreting 12 intradermal allergy tests is certainly as complex or more complex than interpreting a chest x-ray. Given the 4-fold difference in the time-20 minutes vs. 5 minutes-we would consider the recommended value of 0.49 for the battery of tests reasonable in relationship to this commonly performed x-ray procedure
In summary we believe the recommended work value is supported by survey data, by comparison to the reference code, two MPC codes and the x-ray procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree
B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
2005 FIVE YEAR REVIEW - SUMMARY OF RECOMMENDATION

CPT Code:95027 Tracking Number YY3 Specialty Society Recommended RVU: **0.01**
Global Period: XXX RUC Recommended RVU: **0.01**

CPT Descriptor: Intracutaneous (intradermal) tests, sequential and incremental, with allergens extracts for airbourne allergens, immediate type reaction, specify number of tests

The numbers reflected in the table are for a battery of tests in order to allow comparison with the reference codes; data for a single test can be found in the Table in the compelling evidence section.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year old patient reports increased difficulty with head congestion, sneezing and watery eyes with recurrent episodes of wheezing and coughing that are interfering with his work. The patient is seen on referral from his primary care physician. The specialist orders 45 intradermal skin tests (15 allergens at 3 concentration levels for airborne allergenic extracts to determine causes and possible therapies.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician instructs the staff as to which allergens to test for and at what concentrations based on the patient's history, symptoms, and environmental/lifestyle factors.

Description of Intra-Service Work: The physician examines and interprets the nature and extent of the patient's reaction including the size of the erythema and wheal and evaluates the controls in comparison to the test allergens to determine if the test is negative or positive (and if positive, the level of positivity).

Description of Post-Service Work: The physician synthesizes the test results and prepares, reviews and signs the report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Paul Fass, MD, AAOA				
Specialty(s):	American Academy of Otolargyngic Allergy (AAOA)				
CPT Code:	95027				
Sample Size: 100	**Resp N:** 50	**Response:** 50.0 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	10.00	**50.00**	200.00	2000.00
Survey RVW:	0.20	0.81	**1.00**	1.37	6.00
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.00	5.00		15.00	70.00

CPT Code: 95027

Immediate Post Service-Time:	_____	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the key reference service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the key reference service box.

CPT Code: 95027	
	Specialty Recommended
Physician Work RVU:	0.01
Pre-Service Evaluation Time:	0.222
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	0.222

Immediate Post Service-Time:	0.222	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.34	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: a detailed history; a detailed examination; medical decision making of low complexity. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99213	XXX	111,261,211	0.92	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	9,552,729	0.92	RUC Time

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

Other Reference CPT Code	Global	Work RVU	Time Source
99213	XXX	0.92	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.0 %

TIME ESTIMATES (Median)	CPT Code: 95027	Key Reference CPT Code: 99203	Source of Time RUC Time
Median Pre-Service Time	0.222	4.00	
Median Intra-Service Time	0.222	20.00	
Median Immediate Post-service Time	0.222	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**0.666**	**29.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.48	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	2.89
Urgency of medical decision making	3.38	2.96
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.91	3.00
Physical effort required	3.60	3.15
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.71	2.95

Outcome depends on the skill and judgment of physician	3.44	2.98
Estimated risk of malpractice suit with poor outcome	2.28	2.42

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	2.76
Intra-Service intensity/complexity	3.62	3.18
Post-Service intensity/complexity	3.64	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)
Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 95027 is generally provided only by AAOA members and JCAAI did not survey for this code. This code is also valued on a per test basis and typically 45 tests are performed-15 allergens at 3 different concentration levels. Because of the difficulty of valuing the work and time of a single test, the Research Subcommittee agreed that we could survey this service for the full battery of tests. For the battery of 45 tests, the median work value recommended is 1.00 with total time of 30 minutes. Prorating the median work value on a per test basis, results in a work value of 0.02 per test (rounded). This is the value we are recommending.

The table below shows the RVW and time for both the battery of tests and a single test.

95027	Low	25th pctl	Median	75th pctl	High
95027 per test	0.004	0.02	0.02	0.03	0.13
95027 Typical Patient (45 tests)	0.20	0.81	1.00	1.37	6.00
Intra-Service TIME					
95027 per test	0.02	0.20	0.22	0.33	1.00
95027 Typical Patient (45 tests)	1.00	9.25	10.00	15.00	45.0

The remainder of our discussion of the rationale for the recommended value is based on the value for a typical battery of tests which is consistent with survey methodology and which we think is easier to grasp.

We believe that the median work value of 1.00 for interpreting 45 intradermal tests is reasonable and supported by the survey data. The most typically selected reference code was code 99203 which has a work value of 1.34 for total time of 29 minutes. This compares to a work value of 1.00 for total time of 30 minutes. The survey respondents generally considered this code to be more considerably more intense/complex than the reference code for all time segments. Thus, for a service considered more complex and involving similar total time, the recommended work value is about 25 percent lower.

There are no codes on the MPC which are in the same family as allergy testing. We therefore considered codes on the MPC which have XXX global period status-Code 99213 and Code 93307. Code 99213 has a work value of 0.92 for total time of 23 minutes. Since the survey respondents considered the surveyed code to be more complex than the reference code (mid level new patient office visit) it stands to reason that they would similarly consider the surveyed

code to be even more complex than this MPC code. Since the time and complexity is higher, we think the recommended value of 1.0 for the battery of tests is reasonable relative to this code.

Code 93307 has a work value of 0.92 for 28 minutes of total time. Thus, the recommended work value and time are fairly close to this diagnostic procedure.

Finally, we also looked at the values and times assigned to a commonly performed x-ray procedure on the MPC, Code 71020. This code has a work value of 0.22 and total time of 5 minutes. In our judgment, interpreting 45 intradermal allergy tests is certainly as complex or more complex than interpreting a chest x-ray. Given the 6-fold difference in the time-30 minutes vs. 5 minutes-we would consider the recommended value of 1.00 for the battery of tests reasonable in relationship to this commonly performed x-ray procedure..

In summary we believe the recommended work value is supported by survey data, by comparison to the reference code, two MPC codes and the x-ray procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No
   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FIVE YEAR REVIEW SPECIFIC QUESTIONS:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree

B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change

C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change

RUC Recommendation February 2007 RUC Meeting								
	CMS Code	Type	CPT 95004: Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction (per test, based on 40 tests for the typical patient)		CPT 95024: Intracutaneous (intradermal) test with allergenic extracts, immediate type reaction (per test, based on 12 tests for the typical patient)		CPT 95027: intracutaneous (Intradermal) sequential and incremental, with allergens extracts for airbourne allergens, immediate type reaction, specify number of tests	
LOCATION			In office	Out office	In office	Out office	In office	Out office
GLOBAL PERIOD			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
TOTAL CLINICAL LABOR TIME	L037D	Blend	**0.975**	**NA**	**2.23**	**NA**	**2.04**	**NA**
PRE-SERVICE								
Start: When the appointment for the service/procedure is made								
Coordinate pre-service diagnostic & referral forms								
Prep testing board, testing syringes	L037D	Blend	**0.125**		**0.5**		**0.533**	
SERVICE PERIOD								
Start: When patient arrives at office for the service/procedure								
Pre-Service								
Greet patient, provide gowning								
Obtain vital signs								
Education, obtain consent	L037D	Blend	**0.1**				**0.088**	
Prepare room, equipment,supplies	L037D	Blend	**0.05**				**0.044**	
Prepare and position patient	L037D	Blend	**0.05**		**0.17**		**0.044**	
Intra-Service: Perform procedure	L037D	Blend	**0.125**		**0.75**		**0.75**	
Intra-Service: Monitor Patient	L037D	Blend	**0.4**		**0.4**		**0.4**	
Post-Service: Education, instruction, counseling								
ɔst-Service: Monitor Patient following service								
ɔst-Service: Clean room/equipment	L037D	Blend	**0.075**				**0.067**	
Post-Service: Coordinate home or outpatient care, prescriptions								
Post-Service: Charting	L037D	Blend	**0.05**		**0.166**		**0.044**	
End: Patient leaves office								
POST-SERVICE Period								
Start: Patient leaves office								
Phone calls between visits with patient, family phar	L037D	Blend			**0.25**		**0.067**	
Other Clinical Activity (please specify)								
End: When appointment for next service/procedure is made								
MEDICAL SUPPLIES								
Minimum supply package for visits	SA048				**1/12**		**1/45**	
Swab, alcohol	SJ053		**1/20**		**1/6**		**1/6**	
Gauze, non-sterile 2" x 2"	SG052		**1/40**		**1/6**		**1/6**	
Multi-tine device	SC023		**1/8**					
Syringe, 1 ml	SC052				**1/12**		**1/45**	
Topical steroids, gram	SH072		**1/8**		**1/8**		**1/8**	
Color-coded cap and vial	SL027		**1**		**1**		**1**	
Label	SL085				**1**		**1**	
Saline, albumin, 3 cc	SH004		**1**		**1**		**0.5**	
Antigen, 1 ml	SH006		**1**		**1**		**0.33**	
Equipment								
NONE								

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Electronic Analysis of Implanted Neurostimulator Pulse Generator System

The CPT Editorial Panel replaced Category III codes with three new codes to report the electronic analysis of an implanted neurostimulator pulse generator system. Electrical stimulation of the stomach is a treatment for patients with end-stage gastroparesis who are diabetic and/or post-surgical gastroparesis with drug refractory nausea and vomiting. These codes were originally presented at the February 2007 RUC meeting, however, the specialty society requested that this issue be referred to the April 2007 RUC meeting as they believed that their survey data was flawed and wished to conduct a new survey to evaluate these procedures.

95980

The RUC reviewed the specialty society's survey results for CPT code 95980 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming* and thoroughly discussed the physician time and work involved with this service. The RUC agreed with the specialty society that the surveyed physician time for this service does not accurately reflect the service and reduced the surveyed pre-, intra- and post service times dramatically. The specialty society and RUC recommended physician for this procedure are pre-service: 3 minutes, intra-service: 24 minutes, and post-service: 5 minutes. This is an overall reduction of 38 minutes from the surveyed data. The RUC reviewed the specialty society recommended reference service, 93742 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber or wearable cardioverter-defibrillator system, with reprogramming* (Work RVU=0.91). The RUC noted that the intra-service time of the surveyed code was lower than the reference code, 24 minutes and 30 minutes respectively. Additionally, the RUC noted that both codes had similar complexity. Therefore, the RUC agrees with the specialty society recommended value of 0.80 RVUs as this value appropriately places this service in comparison to the reference code, 93742. **The RUC recommends 0.80 work RVUs for 95980.**

95981

The RUC reviewed the specialty society's survey results for CPT code 95981 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming* and thoroughly discussed the physician time and work involved with this service. The RUC agreed with the specialty that the surveyed time for this service does not accurately reflect the service and reduced the surveyed pre-, intra- and post service times dramatically. For this procedure, the physician times that are recommended by the specialty society and the RUC are pre-service: 2 minutes, intra-service: 10 minutes, and post-service: 5 minutes. This is an overall reduction of 13 minutes from the surveyed data. The RUC reviewed the specialty society recommended reference service, 92020 *Gonioscopy*

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(separate procedure) (Work RVU=0.37). The RUC noted that the total-service time of the surveyed code was lower than the reference code, 17 minutes and 20 minutes respectively. Additionally, the RUC noted that both codes had similar complexity. Therefore, the RUC agrees with the specialty society recommended value of 0.30 RVUs as this value appropriately places this service in comparison to the reference code, 92020. **The RUC recommends 0.30 work RVUs for 95981.**

95982

The RUC reviewed the specialty society's survey results for CPT code 95982 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming* and thoroughly discussed the physician time and work involved with this service. The RUC agreed with the specialty that the surveyed time for this service does not accurately reflect the time required to perform the service and reduced the surveyed pre-, intra- and post service times dramatically. For this procedure, the specilaty society and RUC recommended physician times are pre-service: 2 minutes, intra-service: 17 minutes, and post-service: 5 minutes. This is an overall reduction of 13 minutes from the surveyed data. The RUC reviewed the reference service, 99307 *Subsequent nursing facility care,* (Work RVU=0.60). The RUC noted that the total-service time of the surveyed code was higher than the reference code, 24 minutes and 20 minutes respectively. Additionally, the RUC noted that both codes had similar complexity. Therefore, the RUC agrees with the specialty society recommended value of 0.65 RVUs as this value appropriately places this service in comparison to the reference code. **The RUC recommends 0.65 RVUs for 95982.**

Practice Expense:

The RUC made slight modifications were made to the clinical labor time recommended by the specialty society to more accurately reflect the work of the clinical labor performing these procedures. These modifications included the removal of a follow-up phone call in the facility setting, and time reductions in reviewing the patient's chart and preparing the room. All other practice expense recommendations were accepted.

New Technology List:

As these codes were previously reported using the Category III codes, the RUC recommends that these services be added to the New Technology List.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
A simple neurostimulator pulse generator... *Code 95970 describes subsequent...* Code 95980 describes intraoperative electronic analysis of implanted gastric neurostimulator pulse generator system, with programming; code 95981 describes subsequent analysis of the device; code 95982 describes subsequent analysis and reprogramming. For electronic analysis and reprogramming related to the morbid obesity, use 00162T.				
●95980	M1	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability,	XXX	0.80

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
		output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming		
●95981	M2	subsequent, without reprogramming	XXX	0.30
●95982	M3	subsequent, with reprogramming	XXX	0.65
▲0156T		Laparoscopy, surgical; revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity) (For open approach, see 0157T, 0158T) (For insertion of gastric neurostimulator pulse generator, use 64590) (For revision or removal of gastric neurostimulator pulse generator, use 64595) (For electronic analysis and programming of gastric neurostimulator pulse generator, non lesser curvature (ie, morbid obesity), see ~~95999~~ 95980-95982) (For electronic analysis and programming of gastric neurostimulator pulse generator, lesser curvature (ie, 00162T)		N/A
▲0158T		Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity) (For laparoscopic approach, see 0155T, 0156T) (For insertion of gastric neurostimulator pulse generator, use 64590) (For revision or removal of gastric neurostimulator pulse generator, use 64595) (For electronic analysis and programming of gastric neurostimulator pulse generator, non lesser curvature (ie, morbid obesity) see ~~95999~~ 95980-95982)		N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95980 Tracking Number M1 Specialty Society Recommended RVU: **0.80**
Global Period: XXX RUC Recommended RVU: **0.80**

CPT Descriptor: Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedenance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; with interoperative analysis and programming

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old female with medically refractory diabetic gastroparesis is undergoing insertion of a gastric neurostimulator. Interrogation, analysis and programming of the gastric neurostimulator is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Assess for possible contraindications. Discuss with patient the nature of the procedure, why it is being performed and possible complications. Provide instructions to patient on preparation for the procedure. Obtain informed consent.

Description of Intra-Service Work: The physician initially programs the gastric neurostimulator and memory card with the stimulator and patient-related information. The interrogation head is placed in a separate bag. The stimulating wires are placed into the neurostimulator by the physician. The impedance between the stimulating wires is measured and analyzed by the physician. If the impedance is out of range, step-wise repeat interrogation, switching the stimulating polarity of the electrodes, removing and reinserting the stimulating leads into the stimulator, and/or removing and replacing the stimulating wires in the stomach is performed until the impedance is within range. Once the interrogation is completed and the impedance is within 200 to 800 ohms, the information is conveyed to the surgeon to facilitate suturing of the electrodes into the stomach. (The stimulating wires are then removed from the neurostimulator, tunneled through the peritoneum into a pocket in the right lower quandrant, and then reattached to the stimulator by the surgeon (separate procedure)). The physician performing the programming then re-interrogates and analyzes the impedance of the gastric neurostimulator. If the impedance is out of range, the stimulating wires are removed, cleaned, and reattached to the neurostimulator, and the impedance is reassessed by the physician in a step-wise manner with repeat interrogation, switching the stimulating polarity of the electrodes, removing and reinserting the stimulating leads into the stimulator, and/or removing and replacing the stimulating wires until proper range of impedance is achieved. This information is conveyed to the surgeon to facilitate closure of the incision(s) (separate procedure). Upon closure of the incision(s), the impedance of the stimulating wires is reassessed and analyzed by the physician in a step-wise manner with repeat interrogation, switching the stimulating polarity of the electrodes, and/or removing and reinserting the stimulating leads into the stimulator, until the impedance is within the proper range. The stimulation settings are then programmed and reviewed. The stimulation rate, pulse width, cycling on/off times, stimulating electrode selections, and the battery status is verified and recorded by the physician. The gastric neurostimulator is turned on by the physician and the interrogating head is removed.

Description of Post-Service Work: At the conclusion of the procedure, the patient is transferred to the recovery room where vital signs are checked. The physician provides the patient and family members with detailed instructions regarding stimulator operations and stimulator parameters, and instructions on how to perform limited modifications of stimulations parameters (such as pulse width and amplitude) at home upon discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007		
Presenter(s):	Joel V. Brill, MD (AGA), Maurits Wiersema, MD (AGA), John I. Allen, MD, MBA (AGA), Klaus Mergener, MD, PhD, CPE (ASGE)		
Specialty(s):	American Gastroenterological Association (AGA) / American Society for GAstrointestinal Endoscopy (ASGE)		
CPT Code:	95980		
Sample Size: 100	**Resp N:** 15	**Response:** 15.0 %	
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.50	**10.00**	22.00	60.00
Survey RVW:	1.44	1.52	**2.00**	2.05	4.50
Pre-Service Evaluation Time:			**25.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	19.00	**30.00**	52.50	75.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 95980	
	Specialty Recommended
Physician Work RVU:	0.80
Pre-Service Evaluation Time:	3.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	24.00

Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95972	XXX	1.50	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,837,459	0.92	RUC Time

CPT Descriptor 1 Echocardiography, transthoracis, real-time with image documentation (2D) with or without M-mode recording; complete.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
95819	XXX	371,790	1.08	RUC Time

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep.

Other Reference CPT Code	Global	Work RVU	Time Source
99203	XXX	1.34	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 95980	Key Reference CPT Code: 95972	Source of Time RUC Time
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	24.00	60.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**32.00**	**68.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.87	3.53
Urgency of medical decision making	3.67	3.27

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.53
Physical effort required	2.93	2.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.87
Outcome depends on the skill and judgment of physician	3.80	3.60
Estimated risk of malpractice suit with poor outcome	2.93	2.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	2.53
Intra-Service intensity/complexity	3.80	3.60
Post-Service intensity/complexity	2.87	2.67

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of code 95980 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; with intraoperative analysis and programming. *After reviewing the survey data and convening a consensus panel the societies recommend a value of 1.25 work relative value units (WRVUs).*

Survey Process

The survey was disseminated to a list of 100 users of the gastric neurostimulator technology. A list of users was obtained from the American Motility Society and from the manufacturer. A total of 15 (15% response rate) responses were received.

This code was originally surveyed for the February 2007 RUC meeting. The societies requested to resurvey the code in order to determine if the physician scrubs prior to the procedure. Permission to add a question related to scrubbing to the survey was granted by the RUC research subcommittee. The societies held a conference call with survey participants, with proctoring and participation by a RUC member and AMA staff, to address the question of scrub time. Based on responses received and review by the consensus panel it was determined that scrubbing was not typical for this procedure. Scrub time was excluded from the analysis.

Data Evaluation

Due to the low response rate for the survey, a consensus panel comprised of representatives from AGA and ASGE was convened to review the survey data and responses. The low response rate was felt to be due to a small number of physicians, primarily in academic and referral center settings, who perform this procedure on a regular basis.

The panel of advisors compared the survey data to the reference service:

- 95972, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour.

Five (5) respondents (33%) chose reference code 95972. No other code was chosen with such high frequency.

Other codes considered by the consensus panel were:

- 93307 - Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete
- 95819 - Electroencephalogram (EEG); including recording awake and asleep
- 99203 – Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components
- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components

Based on the inclusion of the above codes on the MPC list and the comparability of existing time and WRVU values, the advisors recommended these codes were appropriate comparisons.

The chart below summarizes the data that was considered.

Analysis of Survey Data for 9597X1: Physician Time and WRVU Data for Reference Services						
CPT Code	**Pre Time**	**Intra Time**	**Post Time**	**Total Time**	**WRVU**	**IWPUT**
95980 (Survey 2 – April RUC meeting)	25	30	15	70	1.25**	.012
95980 (Survey 1 – February RUC meeting)	20	30	15	65	1.50***	.020
95972*	3	60	5	68	1.50	.022
93307	5	18	5	28	0.92	.039
95819	5	20	10	35	1.08	.037
99203	4	20	5	29	1.34	.057
99204	5	30	10	45	2.30	.065

* Survey reference service
** Society recommendation at April 2007 RUC meeting
*** Society recommendation at February 2007 RUC meeting

The societies recognized that the physician time elicited from the survey was slightly inflated and this contributed to the low IWPUT for 95980. After comparing the time data and IWPUT values of the surveyed code to the reference codes the advisors concluded that the survey data support the recommended value of 1.25 WRVUs for 9597X1.

95980 versus 95972

The consensus panel considered the difference in intra-service time for these two procedures. Code 95972 has 60 minutes intra-service time versus 30 minutes for 95980. The consensus panel reviewed the survey data and concluded that the 30 minutes of intra-service time identified by the survey participants was the time spent in the intraoperative analysis and programming of the gastric neurostimulator.

The panel noted the survey participants identified additional pre-and post-time for 95980 compared to 95972. When comparing the surveyed code 95980 to the reference service 95972 it was concluded that the lower IPWUT and the corresponding lower WRVU for 9597X1 was appropriate. The panel concluded that this provided additional validation for the recommendation of 1.25 WRVUs for 95980.

95980 versus 93307 and 95819

When comparing 95980 to 93307 and 95819, the consensus panel noted that code 95980 has a higher intra-service time than either 93307 or 95819. The level of intensity of the service and the complexity of medical decision-making was determined to be more complex for 95980compared to these other services. The consensus panel concluded that the WRVU for 95980 was justified based on a relative value comparison with these other services, providing further support for the society's recommendation of 1.25 WRVUs for 95980.

95980 versus 99203 and 99204
When comparing 95980 to 99203 and 99204, the consensus panel was in agreement that the lower WRVU for 95980 was justified. While the total time for 95980 is higher than for 99203 or 99204, and the medical severity of the typical patient seen for 95980 was determined to be as complex as code 99203, the medical decision making associated with codes 99203 and 99204 is more complex. Code 99203 typically deals with medical decision making of low complexity and presenting problems of moderate severity. Code 99204 typically deals with medical complexity of moderate complexity and presenting problems of moderate to high severity. The consensus panel concluded the WRVU for 95980 was justified based on a relative value comparison with these evaluation / management services.

In view of the above, the AGA and ASGE recommend 1.25 WRVUs for surveyed code 95980.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 43647, 090 global, surgeon, 100%; 9597X1, XXX global, gastroenterologist 80% / surgeon 20%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95999, Unlisted neurological or neuromuscular diagnostic procedure

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 3200 Percentage 80.00 %

Specialty Surgery Frequency 800 Percentage 20.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 800 Percentage 80.00 %

Specialty Surgery Frequency 200 Percentage 20.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 93742

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95981 Tracking Number M2 Specialty Society Recommended RVU: **0.30**
Global Period: XXX RUC Recommended RVU: **0.30**

CPT Descriptor: Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulation pulse generator/transmitter; subsequent analysis without reprogramming.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year old female with medically refractory idiopathic gastroparesis has previously undergone placement of a gastric neurostimulator with initial improvement of her symptoms. The patient is now seen for follow-up with complaints of intermittent nausea and postprandial fullness.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Assess for possible contraindications. Discuss with patient the nature of the procedure, why it is being performed and possible complications. Provide instructions to patient on preparation for the procedure. Obtain informed consent.

Description of Intra-Service Work: The interrogation head is placed over the subcutaneous stimulator in the abdomen. The programmer with memory head recognizes the patient's stimulator. Interrogation and measurements of impedance, voltage and current are obtained by the physician, along with the stimulation rate, pulse width, cycling on/off times, stimulating electrode selections, and battery status. These are compared to the settings from the previous visit. The physician determines that no adjustment of the stimulator parameters is required. The stimulation parameters, impedance and operation of the gastric neurostimulator are documented in the patient's medical record. The interrogation procedure is terminated.

Description of Post-Service Work: At the conclusion of the procedure, vital signs are checked, and the results of the analysis are communicated to the patient and caregivers. The physician provides the patient and family members with a copy of the stimulator parameters. Detailed instructions are provided regarding gastric neurostimulator parameters, impedance and operations and limited modifications of stimulations parameters (pulse width and amplitude) at home. Instructions are provided for follow-up care and management, and the patient is discharged when stable.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Joel V. Brill, MD (AGA), Maurits Wiersema, MD (AGA), John I. Allen, MD, MBA (AGA), Klaus Mergener, MD, PhD (ASGE)					
Specialty(s):	American Gastroenterological Association (AGA) / American Society for GAstrointestinal Endoscopy (ASGE)					
CPT Code:	95981					
Sample Size:	100	**Resp N:** 22	**Response:** 22.0 %			
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	11.25	**50.00**	60.00	400.00

CPT Code: 95981

Survey RVW:		0.40	0.45	**0.50**	1.18	2.88
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	10.00	**12.00**	18.75	60.00
Immediate Post Service-Time:	**8.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 95981	
	Specialty Recommended
Physician Work RVU:	**0.30**
Pre-Service Evaluation Time:	**2.0**
Pre-Service Positioning Time:	**0.0**
Pre-Service Scrub, Dress, Wait Time:	**0.0**
Intra-Service Time:	**10.00**
Immediate Post Service-Time:	**5.00**

Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95970	XXX	0.45	**RUC Time**

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,837,459	0.92	**RUC Time**

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
92083	XXX	2,504,632	0.50	**RUC Time**

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
99212	XXX	0.45	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or familly.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 77.2 %

TIME ESTIMATES (Median)	CPT Code: 95981	Key Reference CPT Code: 95970	Source of Time Harvard Time
Median Pre-Service Time	2.00	0.00	
Median Intra-Service Time	10.00	19.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**17.00**	**19.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.36	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.13	3.18
Urgency of medical decision making	3.04	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	3.54
Physical effort required	2.36	2.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.68	2.72
Outcome depends on the skill and judgment of physician	3.41	3.50
Estimated risk of malpractice suit with poor outcome	2.50	2.68

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.73	2.81
Intra-Service intensity/complexity	3.13	3.22
Post-Service intensity/complexity	2.45	2.54

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of code 95981, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis without reprogramming. *After reviewing the survey data and convening a consensus panel the societies recommend a value of 0.30 work relative value units (WRVUs).*

Survey Process

The survey was disseminated to a list of 100 users of the gastric neurostimulator technology. A total of 22 (22% response rate) responses were received. The list of users was obtained from the American Motility Society and from the manufacturer.

This code was originally surveyed for the February 2007 RUC meeting. When the decision was made during that meeting to resurvey code 95980, code 95981 was pulled in order to address the issues with code 95980, and to re-review the original survey data. Code 95981 was not resurveyed and this analysis represents the data from the original survey process.

Data Evaluation

Due to the low response rate a consensus panel comprised of representatives from AGA and ASGE was convened.

The panel of advisors compared the survey data to the reference service:

- 95970, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

A total number of 17 respondents (77%) chose reference code 95970. No other code was chosen with such high frequency.

Code 95970 has a total Harvard time of 19 minutes and is valued at 0.45 WRVUs. In comparison the surveyed code has a total time of 30 minutes. When first presented to the RUC in February 2007, the societies had recommended a WRVU of 0.45. Upon further review and analysis, the consensus panel now recommends a WRVU of 0.30 based on the lower intensity and complexity of this service compared to the reference code 95970, which results in a negative IWPUT of -0.008 for 95981. The panel concluded this negative IWPUT could be the result of survey results with slightly inflated physician time.

Considering the limitations of the survey data and the value of the reference service, the panel recommended a WRVU of 0.30.

Other codes considered by the consensus panel were:

- 92083 - Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
- 99212 - Office or other outpatient visit for the evaluation and management of an established patient
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient
- 95970 - Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
- 77081 - Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
- 93278 - Signal-averaged electrocardiography (SAECG), with or without ECG

Based on these codes' comparability of existing time and WRVU values, the advisors determined that these codes were appropriate additional comparisons.

The chart below summarizes the data that was considered.

Analysis of Survey Data for 95981:
Physician Time and WRVU Data for Reference Services

CPT Code	Pre Time	Intra Time	Post Time	Total Time	WRVU	IWPUT
95981	10	12	8	30	0.30	-.008
95970	--	--	--	19	0.45	--
93307	5	18	5	28	0.92	.039
92083	3	10	0	13	0.50	.043
99212	2	10	4	16	0.45	.032
77081	5	5	10	20	0.22	-0.023
93278	2	4	5	11	0.25	.023

95981 versus 93307 and 92083
When comparing 95981 to 93307 and 92083, the consensus panel noted that code 95981 has a lower intra-service time than either 93307 or 92083. The level of intensity of the service and the complexity of medical decision-making was determined to be less complex for 95981 compared to these other services. The consensus panel concluded that the WRVU recommendation of 0.30 for 95981 was justified based on a relative value comparison with these and other services.

95981 versus 99212
When comparing 95981 to 99212, the consensus panel was in agreement that the lower WRVU for 95981 was justified. While the total time for 95981 is higher than for 99212, the medical severity of the typical patient seen for 95981 was determined to be no more complex than code 99212, which requires straightforward decision making. In code 95981, the patient is seen for follow-up on an outpatient basis, electronic analysis is performed, and the physician determines that no further reprogramming is necessary. The consensus panel concluded the lower WRVU for 95981 was justified based on a relative value comparison with this evaluation / management service.

95981 versus 77081 and 93278
When comparing 95981 to codes 77081 and 93278, the consensus panel noted that the intra-service, pre- and post-times were higher for code 95981 compared to codes 77081 and 93278. The consensus panel carefully considered the physician work and medical decision making associated with code 95981 and noted that even with the potential of slightly inflated times by the survey participants, when comparing code 95981 to codes 77081 and 93278, a higher WRVU for 95981 was justified based on a relative value comparison.

Considering these factors the consensus panel concluded that the available evidence did not support the previous recommendation of 0.45 WRVU, but did support the recommended value of 0.30 WRVUs for 95981.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Codes 99212, 99213, 99214 could be reported if the patient with diabetic gastroparesis has co-existent hypertension requiring a separate evaluation and management service.

Code #	Global	Work	Pre Time	Intra Time	Post Time
99212	XXX	0.45	2	10	4
99213	XXX	0.92	3	15	5
99214	XXX	1.42	5	25	10

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
95999, Unlisted neurological or neuromuscular diagnostic procedure
95970, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 800 Percentage 80.00 %

Specialty Surgery Frequency 200 Percentage 20.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 240 Percentage 80.00 %

Specialty Surgery Frequency 60 Percentage 20.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 92020

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95982 Tracking Number M3 Specialty Society Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulation pulse generator/transmitter; subsequent analysis with reprogramming.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47 year old female with medically refractory idiopathic gastroparesis has previously undergone placement of a gastric neurostimulator with initial improvement of her symptoms. The patient is now seen for follow-up with worsening symptoms and daily complaints of nausea and intermittent vomiting.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Assess for possible contraindications. Discuss with patient the nature of the procedure, why it is being performed and possible complications. Provide instructions to patient on preparation for the procedure. Obtain informed consent.

Description of Intra-Service Work: The interrogation head is placed over the subcutaneous stimulator in the abdomen. The programmer with memory head recognizes the patient's stimulator. Interrogation and measurements of impedance, voltage and current are obtained by the physician, along with the stimulation rate, pulse width, cycling on/off times, stimulating electrode selections, and battery status. These are compared to the settings from the previous visit. It is determined that there has been a change in impedance and thus a change in the current being applied by the neurostimulator.

The physician determines that adjustment of the stimulator parameters is required. The results of the analysis are communicated to the patient. The stimulator interrogation head is re-placed over the patient's subcutaneous stimulator in the right lower quadrant of the abdomen. The physician reprograms the stimulator to achieve the desired impedance, voltage, current and stimulation. When re-programming is successful, and the gastric neurostimulator is delivering the desired mamps of current, the procedure is terminated. All adjustments made to the stimulation parameters, impedance and ongoing operation of the gastric neurostimulator are documented in the patient's medical record.

Description of Post-Service Work: At the conclusion of the procedure, vital signs are checked, and the results of the analysis are communicated to the patient and caregivers. The physician provides the patient and family members with a copy of the stimulator parameters. Detailed instructions are provided regarding gastric neurostimulator parameters, impedance and operations and limited modifications of stimulations parameters (pulse width and amplitude) at home. Instructions are provided for follow-up care and management, and the patient is discharged when stable.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Joel V. Brill, MD (AGA), Maurits Wiersema, MD (AGA), John I. Allen, MD, MBA (AGA), Klaus Mergener, MD, PhD, CPE (ASGE)
Specialty(s):	American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE)
CPT Code:	95982

Sample Size: 100	Resp N: 22	Response: 22.0 %
Sample Type: Convenience		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**30.00**	50.00	400.00
Survey RVW:	0.45	0.84	**1.00**	1.55	2.88
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	15.00	**17.00**	25.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 95982	
	Specialty Recommended
Physician Work RVU:	0.65
Pre-Service Evaluation Time:	2.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	17.00
Immediate Post Service-Time:	5.00

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95973	XXX	0.92	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve, peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with interoperative or susequent programming, each additional 30 minutes after first hour (list seperately in addition to primary procedure).

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
93307	XXX	6,837,459	0.92	RUC Time

CPT Descriptor 1 Echocardiography, Transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99212	XXX	25,078,427	0.45	RUC Time

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99213	XXX	0.92	**RUC Time**

CPT Descriptor ffice or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 45.4 %

TIME ESTIMATES (Median)

	CPT Code: 95982	Key Reference CPT Code: 95973	Source of Time Harvard Time
Median Pre-Service Time	2.00	0.00	
Median Intra-Service Time	17.00	30.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**24.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.38
Urgency of medical decision making	3.09	3.28

Technical Skill/Physical Effort (Mean)

Technical skill required	3.47	3.71
Physical effort required	2.28	2.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.90
Outcome depends on the skill and judgment of physician	3.76	3.76
Estimated risk of malpractice suit with poor outcome	2.57	2.76

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.14	3.23
Intra-Service intensity/complexity	3.47	3.61
Post-Service intensity/complexity	2.71	2.90

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of code 95982, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis with reprogramming. *After reviewing the survey data and convening a consensus panel the societies agreed to recommend a value of 0.65 work relative value units (WRVUs).*

Survey Process

The survey was disseminated to a list of 100 users of the gastric neurostimulator technology. A total of 22 (22% response rate) responses were received. A list of users was obtained from the American Motility Society and from the manufacturer.

This code was originally surveyed for the February 2007 RUC meeting. When the decision was made during that meeting to resurvey code 95980, code 95982 was pulled in order to address the issues with code 95980, and to re-review the original survey data. Code 95982 was not resurveyed and this analysis represents the data from the original survey process.

Data Evaluation

Due to the low response rate a consensus panel comprised of representatives from AGA and ASGE was convened.

The panel of advisors compared the survey data to the reference service:

- 95973, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure).

A total number of 10 respondents (45%) chose reference code 95973. No other code was chosen with such high frequency.

Code 95973 has a total RUC-valued physician time of 30 minutes and is valued at 0.92 WRVUs. In comparison the surveyed code, 95982, has a total physician time of 37 minutes and a recommended WRVU of 0.65. This results in an IWPUT of 0.012 for 95982. When first presented to the RUC in February 2007, the societies had recommended a WRVU of 0.92 for 95982. Upon further review and analysis, the consensus panel now recommends a WRVU of 0.65 based on the lower intensity and complexity of this service compared to the reference code 95973. Although the overall physician time was higher for the surveyed code than the reference service, which is a time based service, the panel agreed that 95982 typically represented a less intensive procedure than 95973 and this lower value recommended for code 95982 was appropriate.

Other codes considered by the consensus panel were:

- 93307 – Subsequent nursing facility care, per day, for the evaluation and management of a patient
- 99212 – Office or other outpatient visit for the evaluation and management of an established patient
- 99213 – Office or other outpatient visit for the evaluation and management of an established patient
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient
- 45330 - Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

The chart below summarizes the data that was considered.

Analysis of Survey Data for 95982:
Physician Time and WRVU Data for Reference Services

CPT Code	Pre Time	Intra Time	Post Time	Total Time	WRVU	IWPUT
95982	10	17	10	37	0.65	.012
95973	--	--	--	30	0.92	--
93307	5	18	5	28	0.92	.039
99212	2	10	4	16	0.45	.032
99213	3	15	5	23	0.92	.049
99307	5	10	5	20	0.60	.038
45330	7	17	8	32	0.96	.037

95982 versus 99212

When comparing 95982 to 99212, the consensus panel determined that the higher WRVU for 95982 was justified. The total time for 95982 is higher than for 99212. The medical severity of the typical patient seen for 95982 was determined to be more complex than code 99212, which requires straightforward decision making. In code 95982, where the patient is seen for follow-up on an outpatient basis, electronic analysis is performed, and the physician determines that further reprogramming is necessary. The consensus panel concluded the higher WRVU for 95981 was justified based on a relative value comparison with this evaluation / management service.

95982 versus 99213 and 93307

When comparing 95982 to codes 99213 and 93307, the consensus panel was in agreement that the lower WRVU for 95982 was justified. While the total time for 95982 is higher than for 99213, the medical severity of the typical patient seen for code 99213 was determined to be more complex than for code 95982. While the intra-time for code 95982 was

1 minute less than code 93307, and the pre- and post- times for code 95982 were higher, the medical severity of the typical patient seen for code 93307 was determined to be more complex than for code 95982. The consensus panel concluded the lower WRVU for 95982 was justified based on a relative value comparison with these evaluation / management services.

95982 versus 99307
When comparing 95982 to codes 99307, the consensus panel determined that the higher WRVU for 95982 was justified. The pre-, intra- and post- time for 95982 is higher than for 99307, and the medical severity of the typical patient seen for code 99307 was determined to be less intense than for code 95982. The consensus panel concluded the higher WRVU for 95982 was justified based on a relative value comparison with this evaluation / management service.

95982 versus 45330
When comparing 95982 to codes 45330, the consensus panel was in agreement that the lower WRVU for 95982 was justified. While the total time for 95982 is equivalent to code 45330, with higher pre- and post- times, the complexity and intensity of code 45330 is higher than for code 95982. The consensus panel concluded the lower WRVU for 95982 was justified based on a relative value comparison with code 45330, a service that is frequently performed by physicians that also perform 95982.

In view of the above, the AGA and ASGE recommend 0.65 WRVUs for surveyed code 95982.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Codes 99212, 99213, 99214 could be reported if the patient with diabetic gastroparesis has co-existent hypertension requiring a separate evaluation and management service.

Code #	Global	Work	Pre Time	Intra Time	Post Time
99212	XXX	0.45	2	10	4
99213	XXX	0.92	3	15	5
99214	XXX	1.42	5	25	10

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

95999, Unlisted neurological or neuromuscular diagnostic procedure
95973, Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 2400 Percentage 80.00 %

Specialty Surgery Frequency 600 Percentage 20.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 640 Percentage 80.00 %

Specialty Surgery Frequency 160 Percentage 20.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 99307

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor:

95980, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; with intraoperative analysis and programming

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
Since most Gastroenterologists do not perform these procedures, input on practice expenses was obtained from physicians who are familiar with these services. A consensus committee including representatives of the American Gastroenterological Association (AGA) and American Society of Gastrointestinal Endoscopy (ASGE) reviewed the data for codes 9597X1, 9597X2 and 9597X3.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- coordinate pre-surgery services with the surgical staff

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:
- conduct a follow-up phone call with patient

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor:

95981, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis without reprogramming

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
Since most Gastroenterologists do not perform these procedures, input on practice expenses was obtained from physicians who are familiar with these services. A consensus committee including representatives of the American Gastroenterological Association (AGA) and American Society of Gastrointestinal Endoscopy (ASGE) reviewed the data for codes 9597X1, 9597X2 and 9597X3. Analysis of the data revealed that these procedures are performed only in the non-facility setting; thus the recommendations were made to price the services only in this setting.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Coordinates pre-surgery service

Intra-Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Conducts a follow-up phone call

CPT Code:_____
Specialty Society('s)_____

AMTA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

95981, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis without reprogramming

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
Since most Gastroenterologists do not perform these procedures, input on practice expenses was obtained from physicians who are familiar with these services. A consensus committee including representatives of the American Gastroenterological Association (AGA) and American Society of Gastrointestinal Endoscopy (ASGE) reviewed the data for codes 9597X1, 9597X2 and 9597X3.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Coordinates pre-surgery service

Intra-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Greets patient
- Obtains 1-3 vitals signs
- Coordinates pre-surgery services
- Locates the stimulator using the programmer
- Manipulates the patient's position based on the physician's directions

- Cleans the room

Post-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Conducts a follow-up phone call

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor:

95982, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis with reprogramming

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
Since most Gastroenterologists do not perform these procedures, input on practice expenses was obtained from physicians who are familiar with these services. A consensus committee including representatives of the American Gastroenterological Association (AGA) and American Society of Gastrointestinal Endoscopy (ASGE) reviewed the data for codes 9597X1, 9597X2 and 9597X3.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Coordinates pre-surgery service

Intra-Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Conducts a follow-up phone call

CPT Code:_____
Specialty Society('s)_____

AMTA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

95982, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis with reprogramming

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
Since most Gastroenterologists do not perform these procedures, input on practice expenses was obtained from physicians who are familiar with these services. A consensus committee including representatives of the American Gastroenterological Association (AGA) and American Society of Gastrointestinal Endoscopy (ASGE) reviewed the data for codes 9597X1, 9597X2 and 9597X3.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Coordinates pre-surgery service

Intra-Service Clinical Labor Activities:

Clinical staff, typically an RN/LPN/MTA blend staff type, conducts the following activities:

- Greets patient
- Obtains 1-3 vitals signs
- Coordinates pre-surgery services
- Locates the stimulator using the programmer
- Manipulates the patient's position based on the physician's directions

	A	B	C	D	E	F	G	H	I
1				95980		95981		95982	
2	Meeting Date: April 2007			Electronic analysis of implanted neurostimulator pulse generator system (e g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; with intraoperative analysis and programming.		Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis without reprogramming		Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements), gastric neurostimulator pulse generator/transmitter; subsequent analysis with reprogramming	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	26.0	3.0	29.0	3.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	3.0	0.0	3.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	23.0	0.0	26.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	3.0	0.0	3.0	0.0
9	PRE-SERVICE								
10	Start: Following visit when decision for surgery or procedure made								
11	Complete pre-service diagnostic & referral forms								
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		3		3		3
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	End:When patient enters office/facility for surgery/procedure								
18	SERVICE PERIOD								
19	Start: When patient enters office/facility for surgery/procedure								
20	Pre-service services								
21	Review charts	L037D	RN/LPN/MTA			2		2	
22	Greet patient and provide gowning	L037D	RN/LPN/MTA			3		3	
23	Obtain vital signs	L037D	RN/LPN/MTA			3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			2		2	
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
26	Setup scope (non facility setting only)								
27	Prepare and position patient/ monitor patient/ set up IV								
28	Sedate/apply anesthesia								
29	Intra-service								
30	Assist physician in performing procedure	L037D	RN/LPN/MTA			8		11	
31	Post-Service								
32	Monitor pt. following service/check tubes, monitors, drains								
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
34	Clean Scope								
35	Clean Surgical Instrument Package								
36	Complete diagnostic forms, lab & X-ray requisitions								
37	Review/read X-ray, lab, and pathology reports								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
39	Discharge day management 99238 --12 minutes								
40	Other Clinical Activity (please specify)								
41	End: Patient leaves office								
42	POST-SERVICE PERIOD								
43	Start: Patient leaves office/facility								
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			3		3	
45	*List Number and Level of Office Visits*								
46	99211 16 minutes		16						
47	99212 27 minutes		27						
48	99213 36 minutes		36						
49	99214 53 minutes		53						
50	99215 63 minutes		63						
51	*Total Office Visit Time*			0	0	0	0	0	0
52	Other Activity (please specify)								
53	End: with last office visit before end of global period								
54	SUPPLIES								
55	Multi-specialty Minimum Supply Package	SA048	1			1		1	
56	EQUIPMENT	CMS Code	Utilization Percentage						
57	Exam Table	EF023	100%			X		X	
58	Neurostimulator programmer	See attachment	100%			X		X	

1682

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Ocular Photoscreening

At the February 2007 CPT Editorial Panel meeting, a pediatric physician provided evidence indicating that since 2003, ocular photoscreening utilization has increased with over 5,000 photoscreening units currently in circulation. The CPT Editorial Panel recognized widespread use of the ocular photo screening Category III code and approved that this code be moved to Category I status.

The RUC initiated the standard Level of Interest process in which specialty societies may survey physicians performing this procedure and present work relative value recommendations to the RUC. No specialty societies indicated an interest in providing a work relative value recommendation.

Ophthalmology and pediatrics both indicated no interest in developing a recommendation for this code. **Therefore, the RUC has no recommendation for physician work or practice expense for code 99174** ***Ocular photoscreening with interpretation and report, bilateral.***

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●99174	UU1	Ocular photoscreening with interpretation and report, bilateral (Do not report code 99174 in conjunction with codes 92002-92014, 99172, 99173)	XXX	No RUC Recommendation
Category III Codes				
D 0065T		~~Ocular photoscreening, with interpretation and report, bilateral~~ ~~(Do not report 00625 in conjunction with 99172 or 99173)~~ (0065T has been deleted. To report, use 99174)		N/A

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Initial Day Hospital Neonate Care

The CPT Editorial Panel created a new inpatient neonate code, 99477 *Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services* to describe the initial day hospital evaluation and management services provided to a sick newborn patient (28 days or less) who requires intensive observation and monitoring, but is not a normal newborn nor meets the CPT definition of critically ill newborn.

The RUC reviewed code 99477 and determined that the survey median work RVU of 7.00 and physician times of 30 minutes pre-service, 77.50 minutes intra-service and 40 minutes post-service were reflect the accurate time spent by the physician. The RUC examined the reference code 99255 *Inpatient consultation for a new or established patient* (work RVU=4.00, physician times = 30 pre, 60 intra, and 25 post) and determined that this reference was appropriate as it was the reference code with the highest RVU and closest comparison offered on the reference service list. The RUC further examined procedures frequently performed during this initial day hospital neonate care service and used a building block analysis to support the survey median of 7.00 RVUs. By adding the reference service code 99255 work RVUs (4.00) and the increments of work for the procedures usually performed in 99477 (2.73, as shown in the calculation below) the total work RVU (6.73) is relative to the survey median 7.00 for 99477. The RUC clarified that typically there are no other services reported with 99477.

Procedures usually performed within 99477 are:
62270 *Spinal puncture, lumbar, diagnostic*
36510 *Catheterization of umbilical vein for diagnosis or therapy, newborn*
36600 *Arterial puncture, withdrawal of blood for diagnosis*
51000 *Aspiration of bladder by needle*
43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*

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90744 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug*

The RUC recommends a work RVU of 7.00 for 99477.

Building Block Analysis for 99477

Code	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	RVW	Total IWPUT	Intra-Service IWPUT
62270	15.00	20.00	10.00	45.00	1.37	0.0405	0.8100
36510	12.00	20.00	10.00	42.00	1.09	0.0299	0.5972
36600	0.00	8.00	0.00	8.00	0.32	0.0400	0.3200
51000	10.00	13.00	10.00	33.00	0.77	0.0248	0.3220
43752	5.00	20.00	5.00	30.00	0.81	0.0293	0.5860
90774	2.00	5.00	2.00	9.00	0.18	0.0181	0.0904
						Total	2.7256
				99255 (4.00) + 2.7256 =			**6.73**

Practice Expense

The RUC recommends no direct practice expense inputs for code 99477 because this service is typically performed in the facility setting.

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

The following codes are...

For initial inpatient encounters...

For admission services for the neonate (28 days of age or less) requiring intensive observation and monitoring services see 99477.

When the patient is admitted...

Evaluation and management services...

Inpatient Neonatal and Pediatric Critical Care Services

The following codes...

The initial day neonatal critical care code...

Codes 99295, 99296...

Codes 99293, 99294...

When a neonate or infant is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, the Continuing Intensive Care Services codes (99298, 99299, 99300) should be used to report services for those neonates/infants with present body weight of 5000 grams or less. When the present body weight of those neonates/infants exceeds 5000 grams, the Subsequent Hospital Care Services codes (99231-99233) should be used. To report initial services to the infant requiring intensive observation, frequent interventions and other intensive care services see 99477.

To report critical care services..

Care rendered under 99293-00206..

The pediatric and neonatal critical care codes include those procedures listed above for the hourly critical care codes (99291, 99292). In addition, the following procedures are also included in the bundled (global) pediatric and neonatal critical care service codes (99293-99296), and the initial and continuing intensive care codes (99477, 99298-99300), umbilical venous (36510) and umbilical arterial catheters (36660), other arterial catheters (36140, 36620), central (36555) or peripheral vessel catheterization (36000), vascular access procedures (36400, 36405, 36406), vascular punctures (36420, 36600), oral or nasogastric tube placement (43752), endotracheal intubation (31500), lumbar puncture (62270), suprapubic bladder aspiration (51000), bladder

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
catheterization (51701, 51702), ventilatory management (94002-94004), continuous positive airway pressure (CPAP) (94660), surfactant administration (94610), intravascular fluid administration (90760-90761), transfusion of blood components (36430, 36440), invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762). Any services performed which are not listed above should be reported separately. *For additional instructions...*				
●99477	N1	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services (For the initiation of inpatient care of the normal newborn report 99431) (For the initiation of care of the critically ill neonate, use 99295) (For initiation of inpatient hospital care of the neonate not requiring intensive observation, frequent interventions, and other intensive care services see 99221-99223)	XXX	7.00

1689

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99477 Tracking Number N1 Specialty Society Recommended RVU: **7.00**
Global Period: XXX RUC Recommended RVU: **7.00**

CPT Descriptor: Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, constant monitoring, and other intensive care services

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2250 gram infant is born at 36-37 weeks gestation by the vaginal route to a mother with unknown Group B Streptococcal Disease status. At six hours of life, the baby develops the sudden appearance of tachypnea, grunting, thermal instability, mild tachycardia and cyanosis responsive to supplemental oxygen. The physician is summoned to the nursery, examines the patient, and admits the infant to the neonatal intensive care unit.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician speaks to the nurse over the telephone and comes to the nursery. The physician again converses with the nurse, reviews the prenatal, labor and delivery summary, and the nursery transitional record over the previous 6 hours of life. The obstetrician is called for further information regarding the antepartum and intrapartum period.

Description of Intra-Service Work: The physician undertakes a complete physical examination of the infant. After completion of the examination, a blood culture, CBC, chest x-ray, and blood glucose are ordered. A spinal tap (62270) is obtained, an umbilical venous catheter (36510) is placed, and a flat plate of the abdomen is ordered to check catheter position. The baby is placed on nasal cannula oxygen and a blood gas is obtained through a radial arterial sample (36600). The physician speaks with the parents, the obstetrician, and the pediatrician.

Description of Post-Service Work: The physician completes the admission history, physical examination, and orders and writes the admission note. The chest radiograph is reviewed for the presence of pneumonia and the flat plate of the abdomen is evaluated for catheter position. The blood gas is reviewed and an appropriate concentration of oxygen is ordered. The CBC, glucose, spinal tap, and urine analysis are evaluated. IV fluids are given and appropriate antibiotics are ordered. The patient is re-evaluated several times during the initial 24 hours of care with changes in oxygen concentration and fluid administration as indicated. The parents, obstetrician, and pediatrician are kept informed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Steve Krug, MD, FAAP, Gil Martin, MD, FAAP, and Rich Molteni, MD, FAAP				
Specialty(s):	American Academy of Pediatrics				
CPT Code:	99477				
Sample Size: 82	**Resp N:** 66	**Response:** 80.4 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	40.00	**60.00**	100.00	400.00
Survey RVW:	2.00	5.20	**7.00**	7.85	100.00

CPT Code: 99477

Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		20.00	60.00	**77.50**	120.00	180.00
Immediate Post Service-Time:	**40.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99477		
		Specialty Recommended
Physician Work RVU:		
Pre-Service Evaluation Time:		
Pre-Service Positioning Time:		
Pre-Service Scrub, Dress, Wait Time:		
Intra-Service Time:		
Immediate Post Service-Time:	____	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x 99292x
Other Hospital time/visit(s):	**0.0**	99231x 99232x 99233x
Discharge Day Mgmt:	**0.0**	99238x 99239x
Office time/visit(s):	**0.0**	99211x 12x 13x 14x 15x
Prolonged Services:	**0.0**	99354x 55x 56x 57x

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99255	XXX	4.00	**RUC Time**

CPT Descriptor Initial inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99296	XXX	22	7.99	**RUC Time**

CPT Descriptor 1 Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99298	XXX	23	2.75	**RUC Time**

CPT Descriptor 2 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 g)

Other Reference CPT Code	Global	Work RVU	Time Source
99223	XXX	3.78	**RUC Time**

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordinatino of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 61 **% of respondents:** 92.4 %

TIME ESTIMATES (Median)

	CPT Code: 99477	Key Reference CPT Code: 99255	Source of Time RUC Time
Median Pre-Service Time	30.00	20.00	
Median Intra-Service Time	77.50	60.00	
Median Immediate Post-service Time	40.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**147.50**	**105.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.55	2.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	3.23
Urgency of medical decision making	3.70	2.73

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.11
Physical effort required	4.14	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	3.36
Outcome depends on the skill and judgment of physician	3.98	2.94
Estimated risk of malpractice suit with poor outcome	3.79	3.02

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.20	3.15
Intra-Service intensity/complexity	4.20	3.32
Post-Service intensity/complexity	4.33	3.24

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was convened. After thorough review of the work survey results, the panel agreed to recommend the survey median of 7.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99223

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 120000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pediatrics Frequency 120000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Code 99298 would be a more appropriate PLI crosswalk since it describes a similar service, albeit for subsequent days of care (as opposed to the initial day of care as described by code 99260X).

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Attestation Statement

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC Advisor, I

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February and April 2007

Team Conferences

In November 2006, the CPT Editorial Panel created CPT codes 99365 *Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by physician* and 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician* to differentiate team conferences at which the patient is present and when the patient is not present.

The CPT Editorial Panel also developed new codes corresponding to non-physician services. The RUC reviewed and submitted the following recommendations on the physician (MD/DO) services only. The HCPAC independently reviewed and submitted separate recommendations on the non-physicians services.

The CPT Executive Committee subsequently reconsidered CPT code 99365. Discussions initiated by the RUC process indicated that team conference services by the physician with the patient and/or family present may be reported using appropriate E/M codes. A research of materials from the creation of the E/M codes indicates that the language concerning face-to-face time and counseling and coordination of care appears to have been included so as to address meetings conducted for the purpose of coordinating care. The Executive Committee confirmed that the E/M codes would be appropriate when counseling and coordination of care dominate the service and the patient and/or family is present. It is unlikely any significant number of team conferences would not be for the purpose of counseling and/or coordination of care. The E/M codes have greater flexibility than a single code for a team conference by a physician, patient and/or family present. Therefore, the RUC proposed the CPT code 99365 be rescinded. The introductory text from the team conference section is revised to account for this interpretation by removing other restrictions and referencing E/M. The requirement for direct participation in the care of the patient remains in response to concerns that the E/M codes would be improperly reported when the physician role was simply to attend a conference about the patient. **The CPT Executive Committee recommends that CPT code 99365 be rescinded.**

The RUC reviewed the survey data for 99367 and compared it to its reference code 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment* (Work RVU=1.10). The RUC agreed that 99374 was a good reference for the surveyed code as both codes are non-face-to-face services. Although, when comparing the two codes, the RUC noted that 99374 was deemed to be a slightly more intense procedure to perform and had slightly more total service time associated with it as compared to the surveyed code (40 minutes and 34 minutes, respectively), the RUC believed these two codes to be equal in overall work. Therefore, the RUC recommends a

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work RVU of 1.10 RVUs for 99367 which is a value slightly below the 25th percentile of the survey data. **The RUC recommends 1.10 work RVUs for 99367.**

Practice Expense:
The RUC recommends no practice expense inputs for 99367.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.~~ Case management is a process in which a physician or another qualified health care professional is responsible for direct care of a patient and, additionally, for coordinating, managing access to, initiating and/or supervising other healthcare services needed by the patient. **Medical Team Conferences** Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (eg, legal guardian) and/or caregivers(s). The participants are actively involved in the development, revision, coordination and implementation of healthcare services needed by the patient. Reporting participants shall have performed face to face evaluations/treatments of the patient, independent of any team conference, within the previous 60 days. Physicians may report their time spent in a team conference with the patient and/or family present using Evaluation and Management codes and time as the key controlling factor for code selection when counseling and/or coordination of care dominates the service. These introductory guidelines do not apply to services reported using Evaluation and Management codes (see E/M services guidelines). However, the physician must be directly involved with the patient, providing face to face services outside of the conference visit with other providers or agencies. Reporting participants shall document their participation in the team conference as well as their contributed information and subsequent treatment recommendations No more than one individual from the same specialty may report 99365-9936X4 at the same encounter. Individuals should not report when their participation in the medical team conference is part of a facility or organizational service contractually provided by the organizational or facility provider.				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
The team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The reporting participant shall be present for all time reported. The time reported is not limited to the time that the participant is communicating to the other team members or patient and/or family. Time reported for medical team conferences may not be used in the determination of time for other services such as care plan oversight (99374-99380), home, domiciliary or rest home care plan oversight (99339-99340), prolonged services (99354-99359), psychotherapy, or any Evaluation and Management service. For team conferences where the patient is present for any part of the duration of the conference, report the team conference face-to-face codes.				
D 99361		~~Medical conference by a physician with interdisciplinary team of health professionals or representatives of coummunity agencies to coordinate activities of patient care (patient not present); approximately 30 minutes~~	XXX	N/A
D 99362		~~approximately 60 minutes~~ (99361, 99362 have been deleted. To report, see 99365-9936X4)	XXX	N/A
Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family				
D •99365	C1	~~Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by physician~~	XXX	The CPT Editorial Panel's Executive Committee has deleted this procedure and has revised the introductory language to reflect this deletion

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medical Team Conference, Without Direct (Face-To-Face) Contact with Patient and/or Family				
•99367	C3	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	XXX	1.10

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99367 Tracking Number C3 Specialty Society Recommended RVU: **1.10**
Global Period: XXX RUC Recommended RVU: **1.10**

CPT Descriptor: Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a neurological disorder, weight loss and functional limitations lives at home with a caregiver. The functional limitations include impaired cognition, mobility, communication and dependencies in basic activities of daily living. The condition is such that the problems and functional limitations are likely to be alleviated with appropriate care and therapies. The optimal care plan needs to be devised in a coordinated manner given the multiple domains requiring attention (biomedical, psychological, social and functional) and multiple healthcare professionals involved in the care of the patient. After undergoing evaluations (each reported separately) by the appropriate disciplines/specialties a team conference is convened.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Chart review prior to conference.

Description of Intra-Service Work: The conference is attended by the physician and/or non-physician providers.

Description of Post-Service Work: This service includes the individual clinician's post conference creation of documentation of his/her participation in the team conference, including documenting contributed information and treatment recommendations, and review of the care plan for the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s):	Alan Lazaroff, MD				
Specialty(s):	American Geriatrics Society, American Academy of Pediatrics, American Psychiatric Association, American Academy of Physical Medicine & Rehabilitation				
CPT Code:	99367				
Sample Size: 192	**Resp N:** 23	**Response:** 11.9 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	5.50	**10.00**	47.50	1000.00
Survey RVW:	0.33	1.15	**1.30**	1.45	2.50
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	45.00
Immediate Post Service-Time: 15.00					

CPT Code: 99367

Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99367	
	Specialty Recommended
Physician Work RVU:	1.10
Pre-Service Evaluation Time:	5.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	30.00

Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99374	XXX	1.10	RUC Time

CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99375	XXX	214,339	1.73	RUC Time

CPT Descriptor 1 Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s),

family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
99242	XXX	1.34	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these three components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 47.8 %

TIME ESTIMATES (Median)

	CPT Code: 99367	Key Reference CPT Code: 99374	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	5.00	9.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**34.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.83	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.52
Urgency of medical decision making	3.00	2.78

Technical Skill/Physical Effort (Mean)

Technical skill required	3.48	3.09
Physical effort required	3.83	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	3.00
Outcome depends on the skill and judgment of physician	3.17	2.74
Estimated risk of malpractice suit with poor outcome	2.57	2.35

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.35	2.91
Intra-Service intensity/complexity	3.74	3.22
Post-Service intensity/complexity	3.13	2.91

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was convened with representatives from AGS. AAP, APA, and AAPMR reviewed changes in recommendations and support the AGS changes.

The description of pre service work says: N/A - this did not go to the respondents and the N/A was incorrect - there is chart review involved before the conference - the surveyees thought this took 10 min - our expert panel thought 5 min was sufficient; the description of post-service work, which also did not go to surveyees, incorrectly included some intraservice work. The only post-service work is the last sentence of the post service work description - specifically, documentation of the physicians participation and any management plan, as appropriate and review of the summary report when it comes out. The surveyees estimated that this took 15 min. We believe that the surveyees may have incorrectly assumed that post service work also included a phone call to the patient or preparing the post conference summary. Therefore, our expert panel reduced the post service time to 5 min.

Work RVUs - Our expert panel recommends 1.1 RVUs for 99367 and 1.20 RVUs for X1. The most appropriate comparator code to 99367 is 99374 which was the reference service chosen most often by respondents. Both codes are non-face-to-face codes and the intensity of 99367 is slightly lower than 99374 because multiple physicians are present at the conference and only a single physician performs 99374. 99374 has an intraservice time of 20 min and a total time of 34 minutes while 99367 has an intraservice time of 30 min and a total time of 40 minutes. The recommended work RVU of 1.1, which is identical to 99374, is based on the longer intraservice time and slightly

lower intensity of 99367 as compared to 99374. This RVU is below the survey 25th percentile and places the two codes in proper rank order.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99361

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Geriatrics How often? Commonly

Specialty Physical Medicine & Rehabilitation How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 802000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Pediatrics Frequency 200000 Percentage 24.93 %

Specialty Geriatrics Frequency 550000 Percentage 68.57 %

Specialty Physical Medicine & Rehabilitation Frequency 2000 Percentage 0.24 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 538,900 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Geriatrics Frequency 522500 Percentage 96.95 %

Specialty Physical Medicine & Rehabilitation Frequency 1400 Percentage 0.25 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor: Medical Team Conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

Sample Size: 9 Response Rate: (%): 56% Global Period: XXX

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

An expert panel was used to develop direct cost inputs. An expert panel was convened with representatives from AGS. AAP, APA, and AAPMR reviewed changes in recommendations and support the AGS changes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None.

Intra-Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

None.

AMTA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Medical Team Conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

Sample Size: 9 Response Rate: (%): 56% Global Period: XXX

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

An expert panel was used to develop direct cost inputs. An expert panel was convened with representatives from AGS. AAP, APA, and AAPMR reviewed changes in recommendations and support the AGS changes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None.

Intra-Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

None.

	A	B	C	F	G
1					
2				CPT Code 99367	
3	Meeting Date: March 26, 2007			Code Descriptor: Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by	
4	LOCATION	Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD			XXX	XXX
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MA	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MA	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	0	0
10	PRE-SERVICE				
11	**Start: When appointment for service is made**				
12	Review/read X-ray, lab, and pathology reports				
13	Other Clinical Activity (please specify)	L037D	RN/LPN/MA	0	0
14	**End: Patient arrival at office for service**				
15	SERVICE PERIOD				
16	**Start: Patient arrival at office for service**				
17	Greet patient and provide gowning	L037D	RN/LPN/MA	0	0
18	Obtain vital signs				
19	Prep and position patient				
20	Prepare room, equipment, supplies				
21	Assist physician during exam	L037D	RN/LPN/MA	0	0
22	Education/instruction/counseling				
23	Coordinate home or outpatient care	L037D	RN/LPN/MA	0	0
24	Clean room/equipment				
25	Other Clinical Activity (please specify)				
26	**End: Patient leaves office**				
27	POST-SERVICE				
28	**Start: Patient leaves office/facility**				
29	Conduct phone calls between visits with patient, family, pharmacy/call in prescriptions	L037D	RN/LPN/MA	0	0
30	Other activity (please specify)				
31	*Total Office Visit Time*			0	0
32	**End: When appointment for next office visit is made**				
33	MEDICAL SUPPLIES	HCPCS Code	Qty		
34	None				
35					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2007

Non Face-to-Face Physician Services

The CPT Editorial Panel created four new codes describing Evaluation and Management services performed by a physician via telephone or on-line. Typically these calls involve the physician obtaining a history of the patient, assessing the patient's condition, making a medical decision and communicating that decision via the phone/e-mail to the patient. Over the last two decades medicine has seen the rapid increase of medical information and communications technology. Combined with changing consumer and health plan expectations for enhanced access to care, a new focus on chronic disease management and continued pressure to reduce the codes of medical services, physicians are providing more care to patients in a "non-face-to-face" manner. Additionally, these services describe physician work that is currently not captured in any other CPT codes.

The CPT Editorial Panel also developed new codes corresponding to non-physician services. The RUC reviewed and submitted the following recommendations on the physician (MD/DO) services only. The HCPAC independently reviewed and submitted separate recommendations on the non-physicians services.

The RUC reviewed the specialty societies' survey results for codes 99441-99444 *Telephone and Online Evaluation and Management services.* Physicians from various specialties perform these services. Therefore, seven different specialties were involved in surveying these services to appropriately capture the typical physician time and work involved. Approximately 500 physicians completed the surveys for 99441-99443, with median annual service performance rates of 190, 100, and 35, respectively. Additionally, 150 physicians completed the survey for code 99444 *Online Evaluation and Management*, indicating a median annual performance rate of 10.

99441
The RUC reviewed the specialty societies survey results for code 99441 *Telephone Evaluation and Management, 5-10 minutes of medical discussion* and thoroughly discussed the physician time and work involved in this service. The RUC determined that the physician time for 99441 was slightly lower than the survey reference service code 99212 *Office or other outpatient visit for the Evaluation and Management of an established patient* (RVU=0.45, 2 minutes pre-, 10 minutes intra- and 4 minutes post-service time). The presenting specialty societies and the RUC agreed that the physician work for code 99441 should be lower than the survey

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reference code 99212 but slightly higher than 99211 *Office or other outpatient visit for the Evaluation and Management of an established patient, that may not require the presence of a physician* (RVU=0.17, 5 minutes intra-service and 2 minutes post-service time). The RUC determined that using a magnitude estimation of 150% of the work RVUs for code 99211 would appropriately place 99441 in the proper rank order within the Evaluation and Management services family (0.17 x 150% = 0.25). **The RUC recommends a work RVU of 0.25 for code 99441. The RUC recommends 1 minute pre-service, 8 minutes intra-service and 4 minutes post-service time for code 99441.**

99442 and 99443

The RUC reviewed the specialty societies survey results for codes 99442 *Telephone Evaluation and Management, 11-20 minutes of medical discussion* and 99443 *Telephone Evaluation and Management, 21-30 minutes of medical discussion* and thoroughly discussed the physician time and work involved in these services. The RUC determined that the RVU presented by the specialty societies for 99442, the 25th percentile work relative value of 0.60, was slightly high in relation to the RUC recommended value for 99441 (0.25 RVUs). The presenting specialty societies and the RUC agreed using a magnitude estimation for 99442 and 99443 would be appropriate to properly values these services within the Evaluation and Management family of services. The RUC determined that 99442 would be twice the recommended value for 99441 (0.25 x 2 = 0.50). Additionally, the RUC determined that 99443 would be three times the recommended value for 99441 (0.25 x 3 = 0.75). **The RUC recommends a work RVU of 0.50 for code 99442 and 1 minute pre-service, 15 minutes intra-service and 5 minutes post-service physician time. The RUC recommends a work RVU of 0.75 for code 99443 and 1 minute pre-service, 25 minutes intra-service and 10 minutes post-service physician time.**

1715

99444

The RUC discussed code 99444 *Online Evaluation and Management* and concluded that the definition of work and physician time and complexity involved in this service were unclear, therefore making it difficult to recommend a specific work relative value. The specialty societies agreed and recommended that code 99444 be carrier-priced. The specialty societies indicated that they will bring this code back to CPT in order to develop a clearer definition of this service. **The RUC recommends that code 99444 be carrier-priced for CY 2008.**

Practice Expense

The PERC and RUC reviewed the direct practice expenses for 99441-99443 and slightly modified the conduct phone calls/call in prescriptions by the RN/LPN/MTA from 4 to 3 minutes and "other clinical activity" to zero. The presumption was that the typical service would include the clinical staff calling in a prescription. **The RUC recommends the modified practice expense as attached.**

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New Technology and New Physician Work

The RUC recommends that codes 99441-99443 be added to the new technology list to review potential changes in valuation after experience in reporting of these services has occurred. Additionally, the RUC recommends that these services involve new physician work not currently compensated within the physician payment system.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Telephone services are non-face-to-face E/M services provided by a physician to a patient using the telephone. These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure and visit. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443 if reporting 99441-99444 performed in the previous seven days.)				
●99441	O1	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	XXX	0.25
●99442	O2	11-20 minutes of medical discussion	XXX	0.50
●99443	O3	21-30 minutes of medical discussion (Do not report 99441-99443 when using 99339-99340, 99374-99380 for the same call(s)) (Do not report 99441-99443 for anticoagulation management when reporting 99363-99364)	XXX	0.75
Online Medical Evaluation An online electronic medical evaluation is a non-face-to-face E/M service by a physician to a patient using Internet resources in response to a patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a secen day period, although multiple physicians				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
could report their exchange with the same patient. If the online medical evaluation refers to an E/M service previously performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous E/M service or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter.				
●99444	O4	Online evaluation and management service provided by a physician to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network (Do not report 99444 when using 99339-99340, 99374-99380 for the same communication(s)) (Do not report 99444 for anticoagulation management when reporting 99363 to 99364)	XXX	Carrier-Priced
~~Telephone Calls~~				
D 99371		~~Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)~~	XXX	N/A
D 99372		~~intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)~~	XXX	N/A
D 99373		~~complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care~~	XXX	N/A

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~plan)~~ ~~(99371-99373 have been deleted. To report telephone evaluation and management services, see 99441-99443)~~		
Category III **Online Medical Evaluation** ~~An online medical evaluation is a type of Evaluation and Management (E/M) service provided by a physician or qualified health care professional to a patient using internet resources in response to the patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service should not be reported for patient contacts (eg, telephone calls) considered to be pre-service or post-service work for other E/M or non E/M services. A reportable service would encompass the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s)~~.				
D 0074T		~~Online evaluation and management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient~~ (0074T has been deleted. To report, use 99444)		N/A

1718

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99441 Tracking Number O1 Specialty Society Recommended RVU: **0.35**
Global Period: XXX RUC Recommended RVU: **0.25**

CPT Descriptor: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient known to the physician calls with a new complaint. The physician obtains a brief history and the patient's present medication use and makes treatment recommendations, all of which are recorded in the patient's medical record. The patient is instructed and advised to call if the symptoms fail to improve with the recommended treatment. The call lasts 8 minutes. No office visit is required.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews records and communicates with other professionals regarding the patient as appropriate.

Description of Intra-Service Work: The physician obtains a brief history via phone, assesses the patients condition, makes a medical decision, and communictates that decision via phone to the patient.

Description of Post-Service Work: The physician documents the telephone call and oversees care plan. The physician also has discussion with family members or other health professionals associated with the delivery of care to this patient until the next E/M service is provided.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Lee Mills, MD (AAFP), Charles Scott, MD (AAP), Robert Stomel, DO (AOA), Eileen Moynihan, MD (ACRh)				
Specialty(s):	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				
CPT Code:	99441				
Sample Size: 4351	**Resp N:** 496	**Response:** 11.3 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	50.00	**190.00**	500.00	4000.00
Survey RVW:	0.04	0.35	**0.45**	0.75	3.77
Pre-Service Evaluation Time:			**2.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	2.00	5.00	**8.00**	10.00	45.00

Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.00 99239x 0.00
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99441		
		Specialty Recommended
Physician Work RVU:		0.35
Pre-Service Evaluation Time:		1.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		8.00
Immediate Post Service-Time:	4.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.45	CMS Time File

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99212	XXX	26,139,270	0.45	CMS Time File

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Most Recent

CPT Code: 99441

MPC CPT Code 2 | Global | Medicare Utilization | Work RVU | Time Source

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 198 **% of respondents:** 39.9 %

TIME ESTIMATES (Median)

	CPT Code: 99441	Key Reference CPT Code: 99212	Source of Time CMS Time File
Median Pre-Service Time	1.00	2.00	
Median Intra-Service Time	8.00	10.00	
Median Immediate Post-service Time	4.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**13.00**	**16.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.06	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.13	2.00
Urgency of medical decision making	2.19	2.04

Technical Skill/Physical Effort (Mean)

Technical skill required	2.15	2.12
Physical effort required	2.00	2.05

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.16	2.13
Outcome depends on the skill and judgment of physician	2.22	2.15
Estimated risk of malpractice suit with poor outcome	2.35	2.21

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.10	2.00
Intra-Service intensity/complexity	2.07	2.03
Post-Service intensity/complexity	2.09	2.04

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The RUC advisors for the participating specialty societies met by conference call to review and discuss the survey results. All of the surveying organizations except the American College of Physicians (ACP) used a panel sample; ACP used a random sample.

For 993XX1, the advisors noted that respondents rated the intensity and complexity of 993XX1 very similar to the key reference code, 99212, with the ratings for 993XX1 being slightly higher in each time segment and for all areas except physical effort. The advisors also noted the nearly identical total time of 993XX1 and 99212. The advisors agreed that 99212 was an appropriate key reference service, since a self-limited or minor presenting problem (as described in 99212) is consistent with a telephone evaluation and management service of 5 to 10 minutes duration (as described in 993XX1). Accordingly, consistent with the survey data, the specialty societies agreed to recommend the survey median of 0.45 work RVUs for 993XX1, which is also the current work RVUs assigned to the key reference code, 99212.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (not applicable)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See attached table.) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 28500200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty (See attached table.) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,586,320 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty (See attached table.) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99442 Tracking Number O2 Specialty Society Recommended RVU: **0.60**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient calls the office of a physician to discuss new acute illness symptoms. The physician obtains a brief history and makes treatment recommendations, all of which are recorded in the patient's medical record. The patient is instructed and advised to call if symptoms are increasing. The call lasts 15 minutes. No office visit is required.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews records and communicates with other professionals regarding the patient as appropriate.

Description of Intra-Service Work: The physician obtains history via phone, assesses the patients condition, makes a medical decision, and communictates that decision via phone to the patient.

Description of Post-Service Work: The physician documents the telephone call and oversees care plan. The physician also has discussion with family members or other health professionals associated with the delivery of care to this patient until the next E/M service is provided.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Lee Mills, MD (AAFP), Charles Scott, MD (AAP), Robert Stomel, DO (AOA), Eileen Moynihan, MD (ACRh)				
Specialty(s):	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				
CPT Code:	99442				
Sample Size:	4351	**Resp N:** 496	**Response:** 11.3 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	30.00	**100.00**	250.00	3000.00
Survey RVW:	0.25	0.60	**0.90**	1.00	4.10
Pre-Service Evaluation Time:			**3.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	4.00	10.00	**15.00**	15.00	50.00

Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99442		
		Specialty Recommended
Physician Work RVU:		0.60
Pre-Service Evaluation Time:		1.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		15.00
Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.92	CMS Time File

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99213	XXX	111,261,211	0.92	CMS Time File

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the

presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 172 **% of respondents:** 34.7 %

TIME ESTIMATES (Median)	CPT Code: 99442	Key Reference CPT Code: 99213	Source of Time CMS Time File
Median Pre-Service Time	1.00	3.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**21.00**	**23.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.64	2.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.56
Urgency of medical decision making	2.83	2.48

Technical Skill/Physical Effort (Mean)

Technical skill required	2.66	2.53

Physical effort required	2.26	2.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.85	2.66
Outcome depends on the skill and judgment of physician	3.39	3.33
Estimated risk of malpractice suit with poor outcome	3.22	2.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.09	2.11
Intra-Service intensity/complexity	3.04	3.10
Post-Service intensity/complexity	2.44	2.39

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The RUC advisors for the participating specialty societies met by conference call to review and discuss the survey results. All of the surveying organizations except the American College of Physicians (ACP) used a panel sample; ACP used a random sample. For 993XX2, the advisors noted that respondents rated the intensity and complexity of 993XX2 very similar to the key reference code, 99213, for each time segment. They also noted that respondents consistently rated the intensity and complexity of 993XX2 higher than 99213 in all areas of mental effort and judgment, technical skill/physical effort, and psychological stress. The advisors also noted the identical time elements (pre-, intra-, and post-service) of 993XX2 and 99213. The advisors agreed that 99213 was an appropriate key reference service, since a presenting problem of low or moderate severity (as described in 99213) is consistent with a telephone evaluation and management service of 11 to 20 minutes duration (as described in 993XX2). Accordingly, consistent with the survey data, the specialty societies agreed to recommend the survey median of 0.90 work RVUs for 993XX2, which is almost the same as the work RVUs assigned to the key reference service, 99213, in 2007.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (not applicable)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See attached table.) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 16762210
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty (See attached table.) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,898,414 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty (See attached table.) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99443 Tracking Number O3 Specialty Society Recommended RVU: **0.92**
Global Period: XXX RUC Recommended RVU: **0.75**

CPT Descriptor: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An established patient with special needs calls to discuss onset of new and disturbing symptoms. During a 25 minute phone call, the physician reviews the history and review of systems, the description of symptoms, and current medications. She makes a recommendation to change the present medication regimen, provides reassurance, both of which are recorded in the patient's medical record, and requests follow-up in the office in one week or sooner if needed.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews records and communicates with other professionals regarding the patient as appropriate.

Description of Intra-Service Work: The physician obtains a history and review of systems via phone, assesses the patients condition, makes a medical decision, and communictates that decision via phone to the patient.

Description of Post-Service Work: The physician documents the telephone call and oversees care plan. The physician also has discussion with family members or other health professionals associated with the delivery of care to this patient until the next E/M service is provided.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007				
Presenter(s):	Lee Mills, MD (AAFP), Charles Scott, MD (AAP), Robert Stomel, DO (AOA), Eileen Moynihan, MD (ACRh)				
Specialty(s):	AAFP, AAN, AAP, ACP, ACRh, AOA, SIR				
CPT Code:	99443				
Sample Size:	4351	**Resp N:** 496	**Response:** 11.3 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	10.00	**35.00**	100.00	5000.00
Survey RVW:	0.32	0.92	**1.35**	1.60	5.60
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	6.00	15.00	**20.00**	25.00	60.00

CPT Code: 99443

Immediate Post Service-Time:	10.00	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☒ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99443		
		Specialty Recommended
Physician Work RVU:		0.92
Pre-Service Evaluation Time:		1.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		25.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.42	CMS Time File

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99214	XXX	55,174,565	1.42	CMS Time File

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Most Recent

CPT Code: 99443

MPC CPT Code 2 | Global | Medicare Utilization | Work RVU | Time Source

CPT Descriptor 2

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)

	CPT Code: 99443	Key Reference CPT Code: 99214	Source of Time CMS Time File
Median Pre-Service Time	1.00	5.00	
Median Intra-Service Time	25.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**36.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.85	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.97
Urgency of medical decision making	3.81	3.91

Technical Skill/Physical Effort (Mean)

Technical skill required	3.49	3.72
Physical effort required	2.98	3.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.74	3.92
Outcome depends on the skill and judgment of physician	3.92	3.97
Estimated risk of malpractice suit with poor outcome	3.69	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.15	3.26
Intra-Service intensity/complexity	3.94	3.95
Post-Service intensity/complexity	3.54	3.77

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The RUC advisors for the participating specialty societies met by conference call to review and discuss the survey results. All of the surveying organizations except the American College of Physicians (ACP) used a panel sample; ACP used a random sample. For 993XX3, the advisors noted that respondents rated the intensity and complexity of 993XX3 similar to and slightly less than that of the key reference code, 99214, for all areas and in each time segment. The advisors also noted the identical pre- and post-service time of 993XX3 and 99214, while intra-service and, therefore, total time, for 993XX3 was just 5 minutes less than 99214. The advisors agreed that 99214 was an appropriate key reference service, since a presenting problem of moderate to high severity (as described in 99214) is consistent with a telephone evaluation and management service of 21 to 30 minutes duration (as described in 993XX3). Accordingly, consistent with the survey data, the specialty societies agreed to recommend the survey median of 1.35 work RVUs for 993XX3, which is less than the current work RVUs assigned to the key reference code, 99214, reflecting the lower intensity and shorter time of the 993XX3.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (not applicable)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See attached table.) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5215455
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty (See attached table.) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 833,881 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty (See attached table.) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

	A	B	C	D	E	F	G
1	RUC Recommendation			99441		99442	
2	Meeting Date: February 2007			Code Descriptor: Non-Face-To-Face Physician Service: Telephone Services		Code Descriptor: Non-Face-To-Face Physician Service: Telephone Services	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			3.0	0.0	3.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	0.0	3.0	0.0
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA	0		0	
17	**End:When patient enters office/facility for surgery/procedure**						
18	SERVICE PERIOD						
19	**Start: When patient enters office/facility for surgery/procedure**						
20	**Pre-service services**						
21	Review charts						
22	Greet patient and provide gowning						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure						
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 –12 minutes 99239 –15 minutes						
40	Other Clinical Activity (please specify)						
41	**End: Patient leaves office**						
42	POST-SERVICE PERIOD						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3		3	
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	*Total Office Visit Time*			0	0	0	0
54	Other Activity (please specify)						
55	**End: with last office visit before end of global period**						
56	MEDICAL SUPPLIES	CMS Code	Unit				
57	NONE						
58							
59	Equipment	CMS Code					
60	NONE						

	A	B	C	H	I	J	K
1	RUC Recommendation			99443		99444	
2	Meeting Date: February 2007			Code Descriptor: Non-Face-To-Face Physician Service: Telephone Services		Code Descriptor:Non-Face-To-Face Physician Servic: Online	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			3.0	0.0	0.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	0.0	0.0	0.0
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA	0		Carrier Priced	
17	**End:When patient enters office/facility for surgery/procedure**						
18	SERVICE PERIOD						
19	**Start: When patient enters office/facility for surgery/procedure**						
20	**Pre-service services**						
21	Review charts						
22	Greet patient and provide gowning						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure						
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 –12 minutes 99239 –15 minutes						
40	Other Clinical Activity (please specify)						
41	**End: Patient leaves office**						
42	POST-SERVICE Period						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3		Carrier Priced	
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	*Total Office Visit Time*			0	0	0	0
54	Other Activity (please specify)						
55	**End: with last office visit before end of global period**						
56	MEDICAL SUPPLIES	CMS Code	Unit				
57	NONE						
58							
59	Equipment	CMS Code					
60	NONE						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Smoking Cessation

In response to recent developments in the area of tobacco control, the CPT Editorial Panel created two new codes to report tobacco counseling cessation services. Currently there are existing G-codes to report these services, G0375 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (CMS Assigned Value of 0.24 RVUs) and G0376 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (CMS Assigned Value of 0.48 RVUs).

99406 - *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*

1743

The RUC reviewed the survey results for CPT code 99406 and agreed with the specialty society that the pre-service and post-service physician times as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified physician times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the smoking cessation counseling would be accounted for in the evaluation and management service. The RUC compared the surveyed code to its reference code 99211 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU=0.17). The RUC noted that the total service times for both codes was the same, 7 minutes. However, the RUC noted that the intensity/complexity measures demonstrated that the surveyed code was a more intense service to provide as compared to the reference code, 99211. Given the same total service time and that the surveyed code has more intensity and complexity associated with it as compared to the reference code, the RUC determined that the current work RVU associated with G0375 would be an appropriate crosswalk for this service, 0.24 RVUs. This proposed value of 0.24 RVUs is slightly higher than the 25th percentile of the survey data. **The RUC recommends 0.24 work RVUs for 99406.**

99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*

The RUC reviewed the survey results for CPT code 99407 and agreed with the specialty society that the pre-service and post-service physician times as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the smoking cessation counseling would be accounted for in the evaluation and management service. The RUC compared the surveyed code to its reference code 99401 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes,* (Work RVU=0.48). The RUC noted that the total service times for both codes was the same, 15 minutes. Further, the RUC noted that the intensity/complexity measures demonstrated that the surveyed code was a more intense service to provide as compared to the reference code. Given the same total service time and that the surveyed code has more

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intensity and complexity associated with it as compared to the reference code, the RUC determined that the median of the survey data of 0.50 RVUs was appropriate. This value is further supported by the current work RVU associated with G0376, 0.48 RVUs. **The RUC recommends 0.50 work RVUs for 99407.**

Practice Expense

The RUC recommends one direct practice expense input associated with both of these procedures, a patient education booklet in the non-facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
These codes are used to report services provided face-to-face by a physician or other qualified healthcare professional ~~to individuals at a separate encounter~~ for the purpose of promoting health and preventing illness or injury. They are distinct from Evaluation and Management services that may be reported separately when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Preventive medicine counseling and risk factor reduction interventions ~~provided as a separate encounter~~ will vary with age and should address such issues as family problems, diet and exercise, substance ~~ab~~use, sexual practices, injury prevention, dental health~~.~~ and diagnostic and laboratory test results available at the time of the encounter. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior, or when performed to change the harmful behavior that has not yet resulted in illness. Any Evaluation and Management (E/M) services reported on the same day must be distinct and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling and arranging for services and follow-up. ~~These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital or consultation or other evaluation and management codes.~~ For counseling groups of patients with symptoms or established illness, use 99078.				
Behavior Change Interventions, Individual **Evaluation and Management Services** **Preventative Medicine Services**				
●99406	VV1	Smoking and tobacco use cessation counseling visit; greater than 3 minutes up to 10 minutes	XXX	0.24

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●99407	VV2	greater than 10 minutes (Do not report code 99407 with 99406)	XXX	0.50
Preventative Medicine, Group Counseling				
99411		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	XXX	0.15 (No Change)
~~G0375~~		~~Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes~~	~~XXX~~	~~0.24~~
~~G0376~~		~~intensive, greater than 10 minutes~~	~~XXX~~	~~0.48~~

1745

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99406 Tracking Number VV1 Specialty Society Recommended RVU: **0.24**
Global Period: XXX RUC Recommended RVU: **0.24**

CPT Descriptor: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year smoker with hypertension and obesity receives a tobacco cessation behavioral intervention

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Specific methods to address barriers to change and avoid relapse are discussed with the patient. The physician assists by prescribing pharmacologic interventions and refers the patient to community support groups. The visit is documented.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Drs. Scott Manaker, ACCP and ACP, Alan Plummer, and ATS					
Specialty(s):	American College of Chest Physicians (ACCP), American Thoracic Society (ATS) and American College of Physicians (ACP)					
CPT Code:	99406					
Sample Size:	200	**Resp N:** 40	**Response:** 20.0 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	15.00	**30.00**	92.50	1000.00
Survey RVW:		0.15	0.20	**0.38**	0.47	0.75
Pre-Service Evaluation Time:				**2.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	5.00	**7.00**	10.00	30.00
Immediate Post Service-Time:	**3.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				

CPT Code: 99406

Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99406	
	Specialty Recommended
Physician Work RVU:	0.24
Pre-Service Evaluation Time:	0.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	7.00

Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99211	XXX	0.17	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99211	XXX	10,302,555	0.17	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99213	XXX	111,146,496	0.92	RUC Time

CPT Descriptor 2 Office or other outpatient visit for the E/M of an established patient, which requires at least two of these three components: an expanded problem focused history; and expanded problem focused exam; and medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99212	XXX	0.45	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires at least two of these three components: a problem focused history; a problem focused exam; and straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 27.5 %

TIME ESTIMATES (Median)

	CPT Code: 99406	Key Reference CPT Code: 99211	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	7.00	5.00	
Median Immediate Post-service Time	0.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**7.00**	**7.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.55	1.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.65	2.36
Urgency of medical decision making	1.91	1.78

Technical Skill/Physical Effort (Mean)

Technical skill required	1.85	1.55

Physical effort required	2.00	1.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.68	1.36
Outcome depends on the skill and judgment of physician	2.45	2.36
Estimated risk of malpractice suit with poor outcome	1.78	1.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.43	2.00
Intra-Service intensity/complexity	3.03	2.91
Post-Service intensity/complexity	1.41	1.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Chest Physicians, American Thoracic Society, and American College of Physicians sent an e-mail to appropriate groups asking them to participate in this survey. Those that expressed interest in surveying were sent the covering e-mail and surveymonkey.com link. A consensus conference was held on March 26, 2007 where it was decided to recommend the existing value (G0375) of 0.24RVUs for 99406. We believe the median value is too high, and the 25th percentile is too low. We have recommended lowering the surveyed pre-service and post-service times.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See last page.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0375

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Other Primary Care How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 32000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. took one hundred fold CMS data

Specialty Pulmonary Frequency 3200 Percentage 10.00 %

Specialty Internal Medicine Frequency 12800 Percentage 40.00 %

Specialty Other Primary Care Frequency 16000 Percentage 50.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,600 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. took ten percent higher than CMS data

Specialty Pulmonary Frequency 160 Percentage 10.00 %

Specialty Internal Medicine Frequency 640 Percentage 40.00 %

Specialty Other Primary Care Frequency 800 Percentage 50.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Code	Pre Time	Intra Time	Post Time	Total Time	Work RVU
99406	**0**	**7**	**1**	**8**	**0.24**
99201	2	10	5	17	**0.45**
99202	2	15	5	22	**0.88**
99203	4	20	5	29	**1.34**
99204	5	30	10	45	**2.30**
99205	7	45	15	67	**3.00**
99211	0	5	2	7	**0.17**
99212	2	10	4	16	**0.45**
99213	3	15	5	23	**0.92**
99214	5	25	10	40	**1.42**
99215	5	35	15	55	**2.00**
99221	10	30	10	50	**1.88**
99222	15	40	20	75	**2.56**
99223	15	55	20	90	**3.78**
99231	5	10	5	20	**0.76**
99232	10	20	10	40	**1.39**
99233	10	30	15	55	**2.00**
99238	8	20	10	38	**1.28**
99239	10	30	15	55	**1.90**
99241	5	15	5	25	**0.64**
99242	5	25	10	40	**1.34**
99243	5	28	7	40	**1.88**
99244	10	40	15	65	**3.02**
99245	10	60	20	90	**3.77**
99251	5	10	5	20	**1.00**
99252	5	25	10	40	**1.50**
99253	10	30	15	55	**2.27**
99254	15	45	20	80	**3.29**
99255	20	60	25	105	**4.00**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99407 Tracking Number VV2 Specialty Society Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year smoker with hypertension and obesity receives a tobaccos cessation behavioral intervention.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Motivational interviewing addressing relevance, risks, rewards, and roadblocks is utilized. Barriers to change and methods to overcome the barriers are discussed , including pharmacologic adjuncts, behavioral techniquest, nicotine replacement, and combining methods. The physician prescribes pharmacolgic aids to tobacco cessation. Referral to a community support group is made. The session is documented.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Drs. Scott Manaker, ACCP, Alan Plummer, ATS, and ACP					
Specialty(s):	American College of Chest Physicians (ACCP), American Thoracic Society (ATS) and American College of Physicians (ACP)					
CPT Code:	99407					
Sample Size:	200	**Resp N:** 40	**Response:** 20.0 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	5.00	**13.50**	56.25	250.00
Survey RVW:		0.35	0.46	**0.50**	0.79	1.00
Pre-Service Evaluation Time:				**2.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	10.00	**15.00**	15.00	45.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				

CPT Code: 99407

Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99407	
	Specialty Recommended
Physician Work RVU:	**0.50**
Pre-Service Evaluation Time:	**0.0**
Pre-Service Positioning Time:	**0.0**
Pre-Service Scrub, Dress, Wait Time:	**0.0**
Intra-Service Time:	**15.00**

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99401	XXX	0.48	**RUC Time**

CPT Descriptor Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99212	XXX	25,078,427	0.45	**RUC Time**

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires at least two of these three components: a problem focused history; a problem focused exam; and straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99214	XXX	59,530,625	1.42	**RUC Time**

CPT Descriptor 2 Office or other outpatient visit for the E/M of an established patient, which requires at least two of these three components: a detailed history; a detailed exam; and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99213	XXX	0.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the E/M of an established patient, which requires at least two of these three components: an expanded problem focused history; and expanded problem focused exam; and medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 32.5 %

TIME ESTIMATES (Median)

	CPT Code: 99407	Key Reference CPT Code: 99401	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**15.00**	**15.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.90	1.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.31
Urgency of medical decision making	2.18	2.23

Technical Skill/Physical Effort (Mean)

Technical skill required	2.38	2.38

Physical effort required	2.51	2.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.08	2.00
Outcome depends on the skill and judgment of physician	2.83	2.46
Estimated risk of malpractice suit with poor outcome	2.00	2.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.63	2.69
Intra-Service intensity/complexity	3.25	3.15
Post-Service intensity/complexity	1.55	1.46

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Chest Physicians, American Thoracic Society, and American College of Physicians sent an e-mail to appropriate groups asking them to participate in this survey. Those that expressed interest in surveying were sent the covering e-mail and surveymonkey.com link. A consensus conference was held on March 26, 2007 where it was decided to recommend the existing value (G0375) of 0.24RVUs for 99406. We believe the median value is too high, and the 25th percentile is too low. We have recommended lowering the surveyed pre-service and post-service times.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See last page.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0376

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Other Primary Care How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. tenfold higher than CMS data

Specialty Pulmonary Frequency 160 Percentage 10.00 %

Specialty Internal Medicine Frequency 640 Percentage 40.00 %

Specialty Other Primary Care Frequency 800 Percentage 50.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 160
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. same as existing data

Specialty Pulmonary Frequency 16 Percentage 10.00 %

Specialty Internal Medicine Frequency 64 Percentage 40.00 %

Specialty Other Primary Care Frequency 80 Percentage 50.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Code	Pre Time	Intra Time	Post Time	Total Time	Work RVU
99407	**2**	**15**	**5**	**22**	**0.50**
99201	2	10	5	17	**0.45**
99202	2	15	5	22	**0.88**
99203	4	20	5	29	**1.34**
99204	5	30	10	45	**2.30**
99205	7	45	15	67	**3.00**
99211	0	5	2	7	**0.17**
99212	2	10	4	16	**0.45**
99213	3	15	5	23	**0.92**
99214	5	25	10	40	**1.42**
99215	5	35	15	55	**2.00**
99221	10	30	10	50	**1.88**
99222	15	40	20	75	**2.56**
99223	15	55	20	90	**3.78**
99231	5	10	5	20	**0.76**
99232	10	20	10	40	**1.39**
99233	10	30	15	55	**2.00**
99238	8	20	10	38	**1.28**
99239	10	30	15	55	**1.90**
99241	5	15	5	25	**0.64**
99242	5	25	10	40	**1.34**
99243	5	28	7	40	**1.88**
99244	10	40	15	65	**3.02**
99245	10	60	20	90	**3.77**
99251	5	10	5	20	**1.00**
99252	5	25	10	40	**1.50**
99253	10	30	15	55	**2.27**
99254	15	45	20	80	**3.29**
99255	20	60	25	105	**4.00**

CPT Code:_99406, 99407

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility and Facility Direct Inputs

CPT Long Descriptor: **99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes**
99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The practice expenses were developed by the ACCP Practice Management Committee and the American Thoracic Society Clinical Practice Committee and discussed at the March 26 consensus conference call with the American College of Physicians. There is good practice-type and geographical representation with the three groups involved.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1							
2				99406		99407	
3	Meeting Date: April 28, 2007			Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes		Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure						
21	Pre-service services						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	Intra-service						
31	Assist physician in performing procedure						
32	Post-Service						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 --12 minutes						
41	Other Clinical Activity (please specify)						
42	End: Patient leaves office						
43	POST-SERVICE Period						
44	Start: Patient leaves office/facility						
45	Conduct phone calls/call in prescriptions						
46							
47	MEDICAL SUPPLIES	CMS Code	Unit				
48	Patient education booklet	SK062		1		1	
49							
50							
51	Equipment	CMS Code	Utilization Percentage				
52							
53							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2007

Alcohol, Drug Screening and Brief Intervention

The CPT Editorial Panel created two new codes to report alcohol, drug screening and brief intervention (SBI). SBI describes a type of physician/patient interaction that requires a significant amount of time and additional skills required by the provider to deliver. SBI techniques are discrete, clearly distinguishable clinical procedures that are effective in identifying and ameliorating an under-treated public health epidemic that affects as many as 20% of adults in the United States.

99408 - *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes*

The RUC reviewed the survey results for CPT code 99408 and agreed with the specialty society that the pre-service and post-service physician time as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the alcohol, drug screening and brief intervention would be accounted for in the evaluation and management service. The RUC compared the surveyed code to its reference code 99402 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes,* (Work RVU=0.98). The RUC noted that the total service times for the reference code were higher than the surveyed code, 30 minutes and 20 minutes respectively. Further, the RUC noted that the intensity/complexity measure of the intra-service time associated with both procedures was identical and therefore demonstrate that the surveyed code has a similar intensity to the reference code. Given the same intensity and complexity and that the surveyed code has less total service time as compared to the reference code, the RUC agreed with the specialty society's recommendation of 0.65 RVUs which is two-thirds of the work RVU associated with the reference code, 99402. **The RUC recommends 0.65 work RVUs for 99408.**

99409 - *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes*

The RUC reviewed the survey results for CPT code 99409 and agreed with the specialty society that the physician time as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the alcohol, drug screening and brief intervention would be accounted for in the evaluation and management service. The RUC agreed with the specialty society's recommendation that this service typically requires double the time to perform in comparison to

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99408 *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes* (RUC recommended Work RVU=0.65). Therefore, the RUC agreed that the appropriate intra-service time for this procedure was 40 minutes. Further the RUC agreed that performing this service would require twice the amount of physician work as 99408 and therefore recommends that 99409 be valued at 1.30 RVUs. The RUC further supported this work RVU by comparing this procedure to 99403 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes* (Work RVU=1.46). Reference code 99403 has slightly more intra-service time as compared to the surveyed code 45 minutes and 40 minutes, respectively with similar intensity. Therefore given its comparison to 99408 and 99403, the RUC agrees that 1.30 work RVUs is an appropriate value for this procedure. **The RUC recommends 1.30 work RVUs for 99409.**

Practice Expense:
The RUC recommends one practice expense input associated with each of these procedures, a patient education booklet in the non-facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
Behavior Change Interventions, Individual **Evaluation and Management Services** **Preventative Medicine Services**				
● 99408	WW1	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes (Do not report services of less than 15 minutes with 99408)	XXX	0.65
● 99409	WW2	greater than 30 minutes (Do not report 99409 with 99408) (Do not report 99408 or 99409 with 99420) (Use codes 99408 and 99409 only for initial screening and brief intervention)	XXX	1.30

1766

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99408 Tracking Number WW1 Specialty Society Recommended RVU: **0.65**
Global Period: XXX RUC Recommended RVU: **0.65**

CPT Descriptor: 994XX3 Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST); and brief intervention (SBI) services, 15 to 30 minutes (Do not report services of less than 15 minutes with 994XX3)

Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior, or when performed to change the harmful behavior that has not yet resulted in illness. Any Evaluation and Management (E/M) services reported on the same day must be distinct and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling and arranging for services and follow-up.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 21 year old college student reports to the school infirmary after injuring his leg after falling down several steps.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The qualified healthcare professional performs an intervention which provides the patient with a specific set of tools and a plan to increase their likelihood of successfully decreasing their alcohol consumption and/or drug use. The components of the intervention include feedback concerning results found with the screening instrument and within the medical record about the quantity and frequency of alcohol (or drugs) consumed by the patient in comparison to national norms; a discussion of negative physical, emotional, occupational consequences that have occurred; and the overall severity of the problem. Feedback is accompanied by advice that is customized to the patient's own unique medical and social situation about clinically appropriate behavioral change goals. The qualified healthcare professional engages the patient in a joint decision-making process regarding alcohol and/or drug use. Plans for follow-up are discussed and agreed to. These interventions have the objective of providing the patient with tools to change their attitude towards alcohol and/or drug use and to manage high-risk use situations. This intervention requires specific training and/or experience in techniques eliciting accurate information, developing a specific treatment plan to which the patient is committed, and motivating the patient toward behavioral change.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Chester Schmidt, M.D., Scott Manaker, M.D., Lee Mills, M.D.
Specialty(s):	American Psychiatric Association, American College of Physicians, American Academy of Family Physicians
CPT Code:	99408

CPT Code: 99408

Sample Size: 125	Resp N: 30	Response: 24.0 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	40.00	**100.00**	130.00	500.00
Survey RVW:	0.30	0.98	**1.10**	1.40	2.30
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	15.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - **proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99408	
	Specialty Recommended
Physician Work RVU:	0.65
Pre-Service Evaluation Time:	0.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	20.00

Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99402	XXX	0.98	RUC Time

CPT Descriptor Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99213	XXX	111,146,496	0.92	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99232	XXX	51,811,800	1.39	RUC Time

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99251	XXX	1.00	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these three key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 16.6 %

TIME ESTIMATES (Median)

	CPT Code: 99408	Key Reference CPT Code: 99402	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**20.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	2.80
Urgency of medical decision making	3.40	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	3.80
Physical effort required	2.20	2.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	2.60
Outcome depends on the skill and judgment of physician	4.00	3.60
Estimated risk of malpractice suit with poor outcome	2.00	2.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.20	2.00
Intra-Service intensity/complexity	4.40	4.40
Post-Service intensity/complexity	2.60	2.40

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Psychiatric Association, American College of Physicians and the American Academy of Family Physicians surveyed 125 psychiatrists, internists and family physicians with experience in screening for and performing interventions around alcohol and/or substance use. Physicians were sent a covering email and a link to the survey housed on surveymonkey.com. A consensus conference was held on April 2, 2007 where it was decided to recommend the median RVU 1.10 for 99408. The median was chosen because the intra service time was lower than the reference code however the intensity, as noted in the survey data, was higher in specific areas than that for the reference code. For instance, we believe the data collection and synthesis of the data is more complex than with a straightforward counseling session. We believe the median post service time from the survey is too high so are recommending a lower time for that segment.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service has not been previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 600,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Based on estimates from WHO and CDC

Specialty Psychiatry Frequency 120000 Percentage 20.00 %

Specialty Internal Medicine Frequency 240000 Percentage 40.00 %

Specialty Family Medicine Frequency 240000 Percentage 40.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 60,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 10% of above

Specialty Psychiatry Frequency 12000 Percentage 20.00 %

Specialty Internal Medicine Frequency 24000 Percentage 40.00 %

Specialty Family Medicine Frequency 24000 Percentage 40.00 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99409 Tracking Number WW2 Specialty Society Recommended RVU: **1.30**
Global Period: XXX RUC Recommended RVU: **1.30**

CPT Descriptor: 994XX4 Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST); and brief intervention (SBI) services, greater than 30 minutes. (Do not report 994XX4 with 994XX3) (Do not report 994XX3 or 994XX4 with 99420) (Use codes 994XX3 and 994XX4 only for initial screening and brief intervention)
(For follow up or counseling services, see E/M)

Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior, or when performed to change the harmful behavior that has not yet resulted in illness. Any Evaluation and Management (E/M) services reported on the same day must be distinct and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling and arranging for services and follow-up.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 21 year old college student reports to the school infirmary after injuring his leg after falling down several steps.

Percentage of Survey Respondents who found Vignette to be Typical: 56%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The qualified healthcare professional performs an intervention which provides the patient with a specific set of tools and a plan to increase their likelihood of successfully decreasing their alcohol consumption and/or drug use. The components of the intervention include feedback concerning results found with the screening instrument and within the medical record about the quantity and frequency of alcohol (or drugs) consumed by the patient in comparison to national norms; a discussion of negative physical, emotional, occupational consequences that have occurred; and the overall severity of the problem. Feedback is accompanied by advice that is customized to the patient's own unique medical and social situation about clinically appropriate behavioral change goals. The qualified healthcare professional engages the patient in a joint decision-making process regarding alcohol and/or drug use. Plans for follow-up are discussed and agreed to. These interventions have the objective of providing the patient with tools to change their attitude towards alcohol and/or drug use and to manage high-risk use situations. This intervention requires specific training and/or experience in techniques eliciting accurate information, developing a specific treatment plan to which the patient is committed, and motivating the patient toward behavioral change.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007
Presenter(s):	Chester Schmidt, M.D., Scott Manaker, M.D., Lee Mills, M.D.

Specialty(s):	American Psychiatric Association, American College of Physicians, American Academy of Family Physicians					
CPT Code:	99409					
Sample Size:	125	**Resp N:**	27	**Response:** 21.6 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	12.50	**25.00**	62.50	200.00
Survey RVW:		0.09	0.73	**1.16**	1.52	2.46
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	13.50	**30.00**	35.00	50.00
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table **- proceed to the new technology/service box.**

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99409	
	Specialty Recommended
Physician Work RVU:	1.30
Pre-Service Evaluation Time:	0.0
Pre-Service Positioning Time:	0.0
Pre-Service Scrub, Dress, Wait Time:	0.0
Intra-Service Time:	40.00

Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.42	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99214	XXX	59,530,625	1.42	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Most Recent

CPT Code: 99409

MPC CPT Code 2	Global	Medicare Utilization	Work RVU	Time Source
99243	XXX	5,130,023	1.88	**RUC Time**

CPT Descriptor 2 Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99252	XXX	1.50	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 11.1 %

TIME ESTIMATES (Median)

	CPT Code: 99409	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	40.00	25.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	3.00
Urgency of medical decision making	3.67	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	4.00
Physical effort required	2.33	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.67
Outcome depends on the skill and judgment of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	2.67	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	2.33
Intra-Service intensity/complexity	4.33	4.33
Post-Service intensity/complexity	3.00	2.67

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Psychiatric Association, the American College of Physicians and the American Academy of Family Physicians surveyed 125 psychiatrists, internists and family physicians with experience in screening for and performing interventions around alcohol and/or substance use. Physicians were sent a covering email and a link to the survey housed on surveymonkey.com. A consensus conference was held on April 2, 2007 to review the data.

The survey data is insufficient and seriously flawed to merit a recommendation based on the data provided for the following reasons: 1) the number of survey respondents did not meet the RUC threshold of 30; 2) it appears from the survey data that the respondents did not follow the CPT descriptor as it indicates that this code is used when the face-to-face portion of the service provided exceeds 30 minutes, while almost half the survey respondents listed an intra-service time of less than 30 minutes; 3) there was wide variation in both times and proposed RVUs for the new services.

In lieu of the survey data we propose using a building block methodology based on the recommended RVU for the 99408. Based on the CPT descriptor, the 99409 can only be used beginning at the 31st minute of intra-service time. The survey data for the 99408 suggests that the median time is 20 minutes; using the building block method, this would suggest that the RVU for 99409 would be 1.5 times greater than the value for 99408. Should 99408 be given a value of 1.1 RVUs then 99409 would be valued at 1.65 RVUs.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service has not been previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 400000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimates from WHO and CDC

Specialty Psychiatry Frequency 100000 Percentage 25.00 %

Specialty Internal Medicine Frequency 150000 Percentage 37.50 %

Specialty Family Medicine Frequency 150000 Percentage 37.50 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 10% of WHO/CDC data

Specialty Psychiatry Frequency 10000 Percentage 25.00 %

Specialty Internal Medicine	Frequency 15000	Percentage 37.50 %
Specialty Family Medicine	Frequency 15000	Percentage 37.50 %

Do many physicians perform this service across the United States? No

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale. NA

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility and Facility Direct Inputs

CPT Long Descriptor: 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST); and brief intervention (SBI) services, 15 to 30 minutes (Do not report services of less than 15 minutes with 99408)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Information on practice expenses related to this code were presented by a representative from the American Psychiatric Association's Committee on RBRVS, Codes and Reimbursements to representatives from the American College of Physicians and the American Academy of Family Physicians during the April 2, conference call. This information had been collected from a diverse group of physicians experienced in providing this service in a range of geographic locations and practice settings.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

NA

Intra-Service Clinical Labor Activities:

NA

Post-Service Clinical Labor Activities:

NA

CPT Code:_____
Specialty Society('s)_____

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility and Facility Direct Inputs

CPT Long Descriptor: 99409 Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST); and brief intervention (SBI) services, greater than 30 minutes. (Do not report 99409 with 99408) (Do not report 99408 or 99409 with 99420) (Use codes 99408 and 99409 only for initial screening and brief intervention) (For follow up or counseling services, see E/M)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Information on practice expenses related to this code were presented by a representative from the American Psychiatric Association's Committee on RBRVS, Codes and Reimbursements to representatives from the American College of Physicians and the American Academy of Family Physicians during an April 2, 2007 conference call. This information had been collected from a diverse group of physicians experienced in providing this service in a range of geographic locations and practice settings.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

NA

Intra-Service Clinical Labor Activities:

NA

Post-Service Clinical Labor Activities:

NA

	A	B	C	D	E	F	G
1							
2				99408		99409	
3	Meeting Date: April 28, 2007			Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST); and brief intervention (SBI) services, 15		Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST); and brief intervention (SBI) services	
4	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	SERVICE PERIOD						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Review charts						
23	Greet patient and provide gowning						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies						
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV						
29	Sedate/apply anesthesia						
30	**Intra-service**						
31	Assist physician in performing procedure						
32	**Post-Service**						
33	Monitor pt. following service/check tubes, monitors, drains						
34	Clean room/equipment by physician staff						
35	Clean Scope						
36	Clean Surgical Instrument Package						
37	Complete diagnostic forms, lab & X-ray requisitions						
38	Review/read X-ray, lab, and pathology reports						
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
40	Discharge day management 99238 --12 minutes 99239 --15 minutes						
41	Other Clinical Activity (please specify)						
42	**End: Patient leaves office**						
43	POST-SERVICE Period						
44	**Start: Patient leaves office/facility**						
45	Conduct phone calls/call in prescriptions						
46	*Office visits*						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54							
55	*Total Office Visit Time*			0	0	0	0
56	Other Activity (please specify)						
57	**End: with last office visit before end of global period**						
58	MEDICAL SUPPLIES	CMS Code	Units				
59	Patient education booklet	SK062		1		1	
60							
61							
62							
63							
64							
65	Equipment	CMS Code	Utilization Percentage				
66							
67							
68							

HCPAC RECOMMENDATIONS

FOR CPT 2008

RUC Meetings:
October 2006, February 2007
and April 2007

AMA
AMERICAN
MEDICAL
ASSOCIATION

May 30, 2007

Leslie Norwalk
Acting Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Norwalk:

It is with pleasure that we submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board, work relative value and direct practice expense inputs for new and revised codes for CPT 2008.

These work relative value and direct practice expense input recommendations address the following new codes:

- Non Face-to-Face Qualified Healthcare Professional Services
- Team Conferences – Participation by Non-Physician Qualified Health Care Professional
- Standardized Cognitive Performance Testing

The CPT Editorial Panel also developed new codes corresponding s for the non face-to-face services and team conference services provided by physicians (MDs/DOs). The RUC reviewed and submitted recommendations on the physician (MD/DO) services only. The HCPAC independently reviewed and submitted separate recommendations on the non-physicians services.

The RUC HCPAC Review Board looks forward to continued CMS representation at our meetings and your effort to ensure a fair review of the enclosed recommendations.

If you have any questions please contact AMA staff, Susan Clark, at (312) 464-4308 or via e-mail at Susan.Clark@ama-assn.org.

Sincerely,

Arthur R. Traugott, MD

Mary Foto, OTR

cc: Gaysha Brooks
Rick Ensor
Edith L. Hambrick, MD
James Hart
Ken Simon, MD
Sherry Smith
Pam West, DPT

HCPAC Review Board

CPT 2008 HCPAC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	HCPAC Date	HCPAC Tab	S.S.	Specialty Rec	HCPAC Rec	Same RVU as last year?	MFS?	Comments
96125	XXX	N	Feb07	85	Standard Cognitive Performance Testing	TT1	HCPAC	U	ASHA, AOTA, NASW	1 86	1 70		☑	
98966	XXX	N	Oct06	06	Non-Face to Face Physician and Qualified Healthcare Professional Services - HCPAC	O5	HCPAC	U	APTA, ADA	0 37	0 25		☑	
98967	XXX	N	Oct06	06	Non-Face to Face Physician and Qualified Healthcare Professional Services - HCPAC	O6	HCPAC	U	APTA, ADA	0 45	0 50		☑	
98968	XXX	N	Oct06	06	Non-Face to Face Physician and Qualified Healthcare Professional Services - HCPAC	O7	HCPAC	U	APTA, ADA	0 50	0 75		☑	
98969	XXX	N	Oct06	06	Non-Face to Face Physician and Qualified Healthcare Professional Services - HCPAC	O8	HCPAC	U	APTA, ADA	0 60	Carrier Priced		☑	
99366	XXX	N	Jun06	06	Team Conference - HCPAC	C2	HCPAC	A	ADA, APA, ASHA, APTA, AOTA, NASW	1 34	0 82		☑	
99368	XXX	N	Jun06	06	Team Conference - HCPAC	C4	HCPAC	A	ADA, APA, ASHA, APTA, AOTA, NASW	1 30	0 72		☑	

Health Care Professionals Advisory Committee
Summary of Recommendations

April 2007

Non Face-to-Face Qualified Healthcare Professional Services

The CPT Editorial Panel created four new codes describing Evaluation and Management services performed by a qualified healthcare professional via telephone or on-line. Typically, these calls involve the health care professional obtaining a history of the patient, assessing the patient's condition, making a medical decision and communicating that decision via the phone/e-mail to the patient. Over the last two decades, medicine has seen the rapid increase of medical information and communications technology. Combined with changing consumer and health plan expectations for enhanced access to care, a new focus on chronic disease management and continued pressure to reduce the codes of medical services, qualified healthcare professionals are providing more care to patients in a "non-face-to-face" manner. Additionally, these services describe work that is currently not captured in any other CPT codes.

The American Dietetic Association (ADA) and the American Physical Therapy Association (APTA), presented work relative value recommendations for the Non Face-to-Face Qualified Health Care Professional Services. The HCPAC reviewed the survey results and compared them to the Non Face-to Face Physician Services. After a detailed discussion, the HCPAC determined that the non-physician work was equivalent to the physician work for codes 98966-98968.

98966
First the HCPAC reviewed code 98966 *Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 5-10 minutes of medical discussion.* The HCPAC determined that the survey median of 0.37 was too high compared to the physician code 99441 *Telephone assessment and management service provided by a physician to an established patient; 5-10 minutes of medical discussion* (work RVU recommendation = 0.25). The HCPAC chose to recommend the same time and work values at the code described to define physician work. The HCPAC agreed that 1 minute pre-service, 8 minutes intra-service and 4 minutes post-service time was appropriate for code 98966. **The HCPAC recommends a work RVU of 0.25 for 98966.**

98967
The HCPAC reviewed code 98967 *Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 11-20 minutes of medical discussion.* The HCPAC determined that the survey median of 0.45 was similar compared to the physician code 99442 *Telephone assessment and management service provided by a physician to an established patient; 11-20 minutes of medical discussion* (work RVU recommendation = 0.50). The HCPAC chose to recommend the same time and work values at the code described

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to define physician work. The HCPAC agreed that 1 minute pre-service, 15 minutes intra-service and 5 minutes post-service time was appropriate for code 98967. **The HCPAC recommends a work RVU of 0.50 for 98967.**

98968
The HCPAC reviewed code *98968 Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient; 21-30 minutes of medical discussion.* The HCPAC determined that the survey median of 0.50 was too low compared to the physician code 99443 *Telephone assessment and management service provided by a physician to an established patient; 21-30 minutes of medical discussion* (work RVU recommendation = 0.75). The HCPAC chose to recommend the same time and work values at the code described to define physician work. The HCPAC agreed that 1 minute pre-service, 25 minutes intra-service and 10 minutes post-service time was appropriate for code 98968. **The HCPAC recommends a work RVU of 0.75 for 98968.**

98969
Lastly, the HCPAC reviewed code 98969 *Online evaluation and management service provided by a qualified non-physician health care professional to an established patient.* The HCPAC concluded, that as the physician code 99444 *Online evaluation and management service provided by a physician to an established patient* (RUC recommendation = carrier-priced), the definition of work and health care professional time and complexity involved in this service was unclear, therefore making it difficult to recommend a specific work relative vale. **The HCPAC recommends that code 98969 be carrier-priced for CY 2008.**

Practice Expense
The PERC and HCPAC reviewed the direct practice expenses for 98966-98968 in February 2007 when these services were initially presented. The practice expense input recommendations are the same as those recommended for the physician non face-to-face services. **The HCPAC recommends 3 minutes post-service phone call by and RN/LPN/MTA for 98966-98968.**

New Technology and New Work
The HCPAC recommends that 98966-98968 be added to the new technology list to review changes in the valuation after experience in reporting these service has occurred (as the physician non face-to-face codes are also recommended to be added to the new technology list). Additionally, the HCPAC recommends that these services involve new work not currently compensated within the physician payment system.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Telephone services are non-face-to-face E/M services provided by a physician to a patient using the telephone. These codes are used to report episodes of care				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure and visit. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443 if reporting 99441-99444 performed in the previous seven days)				
●99441	O1	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	XXX	0.25 (RUC Recommendation)
●99442	O2	11-20 minutes of medical discussion	XXX	0.50 (RUC Recommendation)
●99443	O3	21-30 minutes of medical discussion (Do not report 99441-99443 when using 99339-99340, 99374-99380 for the same call(s)) (Do not report 99441-99443 for anticoagulation management when reporting 99363-99364)	XXX	0.75 (RUC Recommendation)
Online Medical Evaluation An online electronic medical evaluation is a non-face-to-face E/M service by a physician to a patient using Internet resources in response to a patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a secen day period, although multiple physicians could report their exchange with the same patient. If the online medical evaluation refers to an E/M service previously performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous E/M service or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter.				
●99444	O4	Online evaluation and management service provided by a physician to an established patient, guardian or health care provider not originating from a	XXX	Carrier Priced

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network (Do not report 99444 when using 99339-99340, 99374-99380 for the same communication(s)) (Do not report 99444 for anticoagulation management when reporting 99363 to 99364)		(RUC Recommendation)
~~**Telephone Calls**~~				
D 99371		~~Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)~~	XXX	N/A
D 99372		~~intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)~~	XXX	N/A
D 99373		~~complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan)~~ ~~(99371-99373 have been deleted. To report telephone evaluation and management services, see 99441-99443)~~	XXX	N/A
Medicine **Non-Face-to-Face Non-Physician Services**				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Telephone Services Telephone services are non-face-to-face assessment and management services provided by a qualified health care professional to a patient using the telephone. These codes are used to report episodes of care by the qualified health care professional initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or the next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent assessment and management service, procedure and visit. Likewise if the telephone call refers to a service performed and reported by the qualified health care professional within the previous seven days (either provider requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous service or procedure. (Do not report 98966-98969 if reporting 98966-98969 performed in the previous seven days.)				
●98966	O5	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	XXX	0.25
●98967	O6	11-20 minutes of medical discussion	XXX	0.50
●98968	O7	21-30 minutes of medical discussion	XXX	0.75
Online Medical Evaluation An online electronic medical evaluation is a non-face-to-face assessment and management service by a qualified health care professional to a patient using Internet resources in response to a patient's online inquiry. Reportable services involve the provider's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a seven day period, although multiple qualified healthcare professionals could report their exchange with the same patient. If the online medical evaluation refers to an assessment and management service previously performed and reported by the provider within the previous seven days (either provider requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous assessment and management office service or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter.				
●98969	O8	Online evaluation and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care provider not originating from a related assessment and	XXX	Carrier Priced

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		management service provided within the previous 7 days, using the Internet or similar electronic communications network (Do not report 98969 when using 99339-99340, 99374-99380 for the same communication(s)) (Do not report 98969 for anticoagulation management when reporting 99363 to 99364)		
Category III **Online Medical Evaluation** ~~An online medical evaluation is a type of Evaluation and Management (E/M) service provided by a physician or qualified health care professional to a patient using internet resources in response to the patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service should not be reported for patient contacts (eg, telephone calls) considered to be pre-service or post-service work for other E/M or non E/M services. A reportable service would encompass the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s)~~.				
D 0074T		~~Online evaluation and management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient~~ (0074T has been deleted. To report, use 99444)		N/A
Evaluation and Management **Care Plan Oversight** *Care Plan Oversight Services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary*, or non-face-to-face *services. The complexity ...* The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes. (For care plan oversight services of patients in the home, domiciliary, or rest home (eg, assisted living facility) under the individual supervision of a physician, see 99339,99340)				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(Do not report 99374-99380 for time reported with 993X1- 993X4, 98966-98969) **Case Management Services** **Anticoagulant Management** *Anticoagulant services are intended ....* When reporting these services, the work of anticoagulant management may not be used as a basis for reporting an Evaluation and Management service or Care Plan Oversight time during the reporting period. Do not report these services with ~~*99371-99373, 0074T*~~ 99444, 989XX1 – 989XX4 when telephone or on-line address anticoagulation with warfarin management. If a significant, separately identifiable E/M service is performed, report the appropriate E/M service code using modifier 25.				

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98966 Tracking Number O5 Specialty Society Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.25**

CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old female with diabetes requested assistance in how to incorporate a new food product into her meal plan established 3 weeks ago with the Registered Dietitian (RD).

OR

A 40 year old male with a history of anterior cruciate ligament reconstruction of the left knee calls his physical therapist with a complaint of increased discomfort and edema around the knee after performing the home exercise program twice each day. The therapist asked the patient to summarize the home exercise program and a discrepancy was noted in the number of repetitions that the patient was performing and what had been recommended. The therapist reinforced the parameters of the recommended home exercise program, recommended the use of ice following the exercises and instructed the patient to keep their next scheduled therapy appointment. The telephone encounter lasted 10 minutes.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The qualified healthcare professional reviews the patient's phone inquiry, reviews the medical record and the previously prepared exercise program or nutrition plan and goals, and accesses resources to share and discuss with patient.

Description of Intra-Service Work: During the phone conversation, the RD reviews the product's serving size, carbohydrate content and the current meal plan with the patient. The RD counsels the patient on appropriate new product serving size, reinforced adherence to the meal plan, encouraged ongoing completion of food and blood glucose records and reminded patient of her next scheduled appointment.

OR

First, the therapist listened to the patient's complaints. The therapist then asked appropriate questions concerning the home exercise program and use of ice, use of medications, level of activity level during the day, use of a brace and use of an assistive device for gait. The therapist determined that the patient had not properly followed the home exercise instructions and was not applying ice following the home program. The therapist reviewed the home program, made the appropriate recommendations and instructed the patient to keep their next scheduled appointment.

Description of Post-Service Work: The qualified healthcare professional documents the patient interaction in the medical record, notifies the referring physician of the phone call with the patient, and directs staff to mail the summary of instructions provided and educational materials to patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007

Presenter(s):	Jane White, PhD, RD, FADA and Erik van Doorne, PT, DPT, COMT, Cert MDT, FABS					
Specialty(s):	American Dietetic Association and American Physical Therapy Association					
CPT Code:	98966					
Sample Size:	88	**Resp N:**	81	**Response:** 92.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	11.25	**25.00**	100.00	600.00
Survey RVW:		0.05	0.25	**0.37**	0.45	1.04
Pre-Service Evaluation Time:				**3.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	10 00	**10.00**	10 00	90.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20), 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60), 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 98966		
		Specialty Recommended
Physician Work RVU:		0.37
Pre-Service Evaluation Time:		1.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		8.00
Immediate Post Service-Time:	4.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
97110	XXX	0.45	RUC Time

CPT Descriptor Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strenght and endurance, range of motion and flexibility

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
97110	XXX	27,865,000	0.45	RUC Time

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor .

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 28.0 %

TIME ESTIMATES (Median)	CPT Code: 98966	Key Reference CPT Code: 97110	Source of Time RUC Time
Median Pre-Service Time	1.00	2.00	
Median Intra-Service Time	8 00	14.00	
Median Immediate Post-service Time	4.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**13.00**	**18.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	3.08
Urgency of medical decision making	3.45	2.96
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.40	3.63
Physical effort required	1.57	3.46
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.18	2.83
Outcome depends on the skill and judgment of physician	3.82	3.63

Estimated risk of malpractice suit with poor outcome	3 38	3.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.74	2.50
Intra-Service intensity/complexity	3.43	3.71
Post-Service intensity/complexity	2.20	2 71

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ADA and APTA recommend the above RVU and Pre-, Intra-, and Post-service times even though both data sets had variability in the reported reference service codes. Based on the distinct services provided by both professionals, as described in the vignettes, and the professionals' experience completing the work survey, we anticipated differences in the reported reference service code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Not previously reported

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ADA How often? Commonly

Specialty APTA How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 875000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Compiled frequency estimates from MDs, APTA and ADA.

Specialty ADA Frequency 775000 Percentage 88.57 %

Specialty APTA Frequency 100000 Percentage 11.42 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 462,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty ADA Frequency 362000 Percentage 78.35 %

Specialty APTA Frequency 100000 Percentage 21.64 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98967 Tracking Number 06 Specialty Society Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year old male with insulin dependent diabetes, called the Registered Dietitian (RD) with a complaint of several mid-morning low blood sugar readings following the implementation of his 30-minute, new exercise regimen.

OR
A 54 year old woman with a history of rheumatoid arthritis and metacarpalphalangeal arthroplasties of her dominant hand called her occupational therapist because of post-operative pain and difficulty with use of the dynamic outrigger orthotic during the day and positioning at night. The therapist reviewed the patient's understanding of the instructions that had been provided at the last office visit and made specific recommendations regarding number of repetitions of the exercises, elevation of the extremity to help reduce edema, recommendations for positioning during the night, and use of cold applications for temporary pain relief . The telephone encounted lasted 15 minutes.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The qualified healthcare professional reviews the patient's phone inquiry, reviews the medical record and the previously prepared exercise program or nutrition plan and goals, and accesses resources to share and discuss with patient.

Description of Intra-Service Work: The RD verifies the patient's understanding of his hypoglycemia management and reviewed the patient's self-reported glucose monitoring records. After discussion of the prescribed meal plan provided at the last office visit, the RD reviews the patient's understanding of his meal plan and pre-workout meal regimen, and reinforces concepts to avoid hypoglycemia with future exercise.
OR
The therapist listened to the patient's complaints. The therapist then asked appropriate questions concerning tolerance to the orthotic (e.g.wearing time, exercise in the outrigger, pressure points), elevation of the extremity during the day and night, medication use, home exercise program, and management of ADLs. Recommendations were made regarding the specific exercises that should be performed including number of repetitions and frequency, positioning of the limb during the day and at night, precautions regarding skin integrity and protection of the sutures, and use of ice to help control pain.

Description of Post-Service Work: The qualified healthcare professional documents the patient interaction in the medical record, notifies the referring physician of the phone call with the patient, and directs staff to mail the summary of instructions provided and educational materials to patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007				
Presenter(s).	Jane White, PhD, RD, FADA and Erik van Doorne, PT, DPT, COMT, Cert. MDT, FABS				
Specialty(s):	American Dietetic Association and American Physical Therapy Association				
CPT Code:	98967				
Sample Size:	88	**Resp N:** 80	**Response:** 90.9 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0 00	5.00	**20.00**	50.00	500.00
Survey RVW:	0.10	0.36	**0.45**	0.65	1.21
Pre-Service Evaluation Time:			**3.5**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	15.00	**15.00**	20.00	90.00
Immediate Post Service-Time:	**5.00**				
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**			
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**			
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**			
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30), 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 98967		
		Specialty Recommended
Physician Work RVU:		**0.45**
Pre-Service Evaluation Time:		**1.0**
Pre-Service Positioning Time:		**0.0**
Pre-Service Scrub, Dress, Wait Time:		**0.0**
Intra-Service Time:		**15.00**
Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
97002	XXX	0.60	**RUC Time**

CPT Descriptor Physical Therapy re-evaluation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
97110	XXX	27,865,000	0.45	**RUC Time**

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor .

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)

	CPT Code: 98967	Key Reference CPT Code: 97002	Source of Time RUC Time
Median Pre-Service Time	1.00	2.00	
Median Intra-Service Time	15.00	18.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**21.00**	**25.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	3.41
Urgency of medical decision making	3.72	3 18

Technical Skill/Physical Effort (Mean)

Technical skill required	3.66	4.00
Physical effort required	1.84	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.74	3.24
Outcome depends on the skill and judgment of physician	3.92	3.82
Estimated risk of malpractice suit with poor outcome	3.59	3.24

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.04	2.29
Intra-Service intensity/complexity	3.88	4.12
Post-Service intensity/complexity	2.70	2.71

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ADA and APTA recommend the above RVU and Pre-, Intra-, and Post-service times even though both data sets had variability in the reported reference service codes. Based on the distinct services provided by both professionals, as described in the vignettes, and the professionals' experience completing the work survey, we anticipated differences in the reported reference service code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Not previously reported

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ADA	How often? Commonly
Specialty APTA	How often? Commonly
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 567100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Compiled frequency estimates from MDs, APTA and ADA.

Specialty ADA	Frequency 467100	Percentage 82.36 %
Specialty APTA	Frequency 100000	Percentage 17.63 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 359,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty ADA	Frequency 259500	Percentage 72.18 %
Specialty APTA	Frequency 100000	Percentage 27.81 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98968 Tracking Number 07 Specialty Society Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.75**

CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old female with congestive heart failure calls the Registered Dietitian (RD) based on concerns about lower extremity edema following consumption of foods served at a family reunion.

OR
The parent of an 15 year old male with a history of recent T10 spinal cord injury called the physical therapist regarding the recommended home exercise program, proper positioning and seating in the wheelchair, and a newly discovered area of skin irritation on the right buttock. The therapist inquired as to the current exercise program that was being followed including the frequency and intensity of the exercises, the length of time the patient was spending in the wheelchair, the extent of the patient's management of his transfers and mobility in the wheelchair as well as specific inquiries concerning the area of possible skin breakdown on the buttocks. The therapist reviewed and modified the home program, and made recommendations regarding the length of time continuously spent in the wheelchair and precautions to maintain skin integrity It was recommended that the patient return for follow-up within one week unless the skin irritation did not improve or worsened.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The qualified healthcare professional reviews the patient's phone inquiry, reviews the medical record and the previously prepared exercise program or nutrition plan and goals, and accesses resources to share and discuss with patient.

Description of Intra-Service Work: The RD reviews the patient's recent food intake and compared it to the prescribed meal pattern- paying particular attention to sodium and fluid consumption. The RD identifies high sodium foods that contributed to the patient's current symptoms, and counsels the patient on lower sodium alternatives. The RD counsels the patient on her daily fluid recommendations and encouraged the patient to measure her fluid consumption and body weight daily. The RD instructs the patient to call and report any weight fluctuation greater than 2-3 lbs/day. The RD recommends that the patient return for follow-up in 1-2 weeks unless rapid weight gain, increased shortness of breath, or other symptoms of worsening heart failure occurred in which case the patient is told to call her physician.

or
The therapist listened to the patient's complaints and parental concerns. The therapist then asked appropriate questions of the patient and parent concerning the time spent in the wheelchair in and out of the home environment, level of activity during the day while in the chair, description of the skin irritation on the buttocks, participation in the home exercise program and management of mobility, transfers in and out of the wheelchair and ADLs. The therapist made recommendations concerning transfer techniques in and out of the chair to reduce friction force on the buttocks, duration of sitting time in the wheelchair including recommendations to spend additional time each day lying prone so that the skin irritation could heal. Recommendations were also made concerning pressure relief strategies while in the chair and

revisions to the home exercise program were suggested. The therapist recommended a follow-up visit within one week unless the skin irritation did not improve or worsened.

Description of Post-Service Work: The qualified healthcare professional documents the patient interaction in the medical record, notifies the referring physician of the phone call with the patient, and directs staff to mail the summary of instructions provided and educational materials to patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2029					
Presenter(s):	Jane White, PhD, RD, FADA and Erik van Doorne, PT, DPT, COMT, Cert. MDT, FABS					
Specialty(s):	American Dietetic Association and American Physical Therapy Association					
CPT Code:	98968					
Sample Size:	86	**Resp N:** 78	**Response:** 90.6 %			
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0 00	1 00	**10.00**	17 50	500.00
Survey RVW:		0 15	0.44	**0.50**	0.75	1.21
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		2.00	22.00	**25.00**	30.00	90.00
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (70), 99292 (30); 99231 (20); 99232 (40), 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55), 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 98968		
		Specialty Recommended
Physician Work RVU:		0.50
Pre-Service Evaluation Time:		1.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		25.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
97002	XXX	0.60	RUC Time

CPT Descriptor Physical therapy re-evaluation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
97110	XXX	27,865,000	0.45	RUC Time

CPT Descriptor 1

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 28.2 %

TIME ESTIMATES (Median)

	CPT Code: 98968	Key Reference CPT Code: 97002	Source of Time
Median Pre-Service Time	1.00	2.00	
Median Intra-Service Time	25.00	18.00	
Median Immediate Post-service Time	10.00	5.00	
Median Critical Care Time	0 0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0 0	0.00	
Median Total Time	**36.00**	**25.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3 55
Urgency of medical decision making	4 09	3.32

Technical Skill/Physical Effort (Mean)

Technical skill required	3.96	3.95
Physical effort required	1.87	3 27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.21	3.23
Outcome depends on the skill and judgment of physician	4.19	4.05
Estimated risk of malpractice suit with poor outcome	3.98	3.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.11	2.32
Intra-Service intensity/complexity	4.09	4.18
Post-Service intensity/complexity	2.91	2.77

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ADA and APTA recommend the above RVU and Pre-, Intra-, and Post-service times even though both data sets had variability in the reported reference service codes. Based on the distinct services provided by both professionals, as described in the vignettes, and the professionals' experience completing the work survey, we anticipated differences in the reported reference service code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Not previously reported

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ADA How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 383907
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty ADA Frequency 283907 Percentage 73.95 %

Specialty APTA Frequency 100000 Percentage 26.04 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 232,667 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty ADA Frequency 132667 Percentage 57.02 %

Specialty APTA Frequency 100000 Percentage 42.97 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Dietetic Association utilized an expert panel to discuss and prepare practice expense recommendations for the non-face-to-face codes, 98966-X4. The expert panel consisted of six registered dietitian practitioners from a variety of practice settings and geographical locations. The American Physical Therapy Association convened a group of five physical therapists familiar with the services described by the codes was consulted. Their consensus opinion was then coordinated with other societies who surveyed similar codes (993X1 - X4).

Both expert panels' data and description of the clinical staff's pre- and post-service activities were identical, so both group's data was merged.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff receives the call from the patient. Clinical staff requests the patient's medical record and collects the health care professional's documentation note from the patient's last appointment. Clinical staff discusses patient's phone inquiry with the health care professional. The decision is made to have the health care professional call the patient to discuss the problem.

Intra-Service Clinical Labor Activities:
NA

Post-Service Clinical Labor Activities:
The clinical staff collects materials discussed over the call from the health care professional and mails educational print materials and summary of exercise or nutrition plan to the patient and physician. The patient's chart is filed in the health care professional's office.

Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Dietetic Association utilized an expert panel to discuss and prepare practice expense recommendations for the non-face-to-face codes, 989X1-X4. The expert panel consisted of six registered dietitian practitioners from a variety of practice settings and geographical locations. The American Physical Therapy Association convened a group of five physical therapists familiar with the services described by the codes was consulted. Their consensus opinion was then coordinated with other societies who surveyed similar codes (993X1 - X4).

Both expert panels' data and description of the clinical staff's pre- and post-service activities were identical, so both group's data was merged.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff receives the call from the patient. Clinical staff requests the patient's medical record and collects the health care professional's documentation note from the patient's last appointment. Clinical staff discusses patient's phone inquiry with the health care professional. The decision is made to have the health care professional call the patient to discuss the problem.

Intra-Service Clinical Labor Activities:
NA

Post-Service Clinical Labor Activities:
The clinical staff collects materials discussed over the call from the health care professional and mails educational print materials and summary of exercise or nutrition plan to the patient and physician. The patient's chart is filed in the health care professional's office.

Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Dietetic Association utilized an expert panel to discuss and prepare practice expense recommendations for the non-face-to-face codes, 989X1-X4. The expert panel consisted of six registered dietitian practitioners from a variety of practice settings and geographical locations.
The American Physical Therapy Association convened a group of five physical therapists familiar with the services described by the codes was consulted. Their consensus opinion was then coordinated with other societies who surveyed similar codes (993X1 - X4).

Both expert panels' data and description of the clinical staff's pre- and post-service activities were identical, so both group's data was merged.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff receives the call from the patient. Clinical staff requests the patient's medical record and collects the health care professional's documentation note from the patient's last appointment. Clinical staff discusses patient's phone inquiry with the health care professional. The decision is made to have the health care professional call the patient to discuss the problem.

Intra-Service Clinical Labor Activities:
NA

Post-Service Clinical Labor Activities:
The clinical staff collects materials discussed over the call from the health care professional and mails educational print materials and summary of exercise or nutrition plan to the patient and physician. The patient's chart is filed in the health care professional's office.

	A	B	C	D	E	F	G	H	I	J	K
2	HCPAC Recommendation			CPT Code: 98966		CPT Code: 98967		CPT Code: 98968		CPT Code:98969	
3	Meeting Date: April 2007			98966 CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion		98967 CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.		98968 CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.		98969 CPT Descriptor: Online evaluation and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network.	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			6.0	0.0	3.0	0.0	3.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	0.0	3.0	0.0	3.0	0.0	0.0	0.0
10	PRE-SERVICE										
11	**Start. Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity (please specify) receive and transcribe phone message, pull medical record and other materials for health care professional's review,	0 370	RN/LPN/MTA	0		0		0		Carrier Priced	
18	**End:When patient enters office/facility for surgery/procedure**										
19	SERVICE PERIOD										
20	**Start: When patient enters office/facility for surgery/procedure**										
21	**Pre-service services**										
22	Review charts										
23	Greet patient and provide gowning										
24	Obtain vital signs										
25	Provide pre-service education/obtain consent										
26	Prepare room, equipment, supplies										
27	Setup scope (non facility setting only)										
28	Prepare and position patient/ monitor patient/ set up IV										
29	Sedate/apply anesthesia										
30	**Intra-service**										
31	Assist physician in performing procedure										
32	**Post-Service**										
33	Monitor pt following service/check tubes, monitors, drains										
34	Clean room/equipment by physician staff										
35	Clean Scope										
36	Clean/Surgical Instrument Package										
37	Complete diagnostic forms, lab & X-ray requisitions										
38	Review/read X-ray, lab, and pathology reports										

	A	B	C	D	E	F	G	H	I	J	K
2	**HCPAC Recommendation**			**CPT Code: 98966**		**CPT Code: 98967**		**CPT Code: 98968**		**CPT Code.98969**	
3	**Meeting Date: April 2007**			**98966 CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion**		**98967 CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.**		**98968 CPT Descriptor: Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.**		**98969 CPT Descriptor: Online evaluation and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network.**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
40	Discharge day management 99238 --12 minutes 99239 --15 minutes										
41	Other Clinical Activity (please specify)										
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions, send materials to patient and physician, file chart		RN/LPN/MTA	3		3		3		Carrier Priced	
46	*Office visits* Greet patient,escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results,assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care										
47	*List Number and Level of Office Visits*										
48	99211 16 minutes		16								
49	99212 27 minutes		27								
50	99213 36 minutes		36								
51	99214 53 minutes		53								
52	99215 63 minutes		63								
53	Other										
54											
55	*Total Office Visit Time*			0	0	0	0	0	0	0	0
56	Other Activity (please specify)										
57	**End: with last office visit before end of global period**										

	A	B	C	D	E	F	G	H	I	J	K
2	HCPAC Recommendation			CPT Code: 98966		CPT Code: 98967		CPT Code: 98968		CPT Code:98969	
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4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
58	MEDICAL SUPPLIES	CMS Code	Unit								
59											
60											
61											
62											
63											
64											
65											
66	Equipment	CMS Code	Utilization Percentage								
67											
68											
69											

RUC HCPAC Review Board
Summary of Recommendations

February 2007

Team Conferences

The CPT Editorial Panel created CPT codes 99366 *Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional* and 99368 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional* to differentiate team conferences at which the patient is present and when the patient is not present and differentiate the various healthcare professionals who may participate in the team conference.

The HCPAC reviewed the specialty societies survey results for codes 99366 and 99368. These services are performed by a health care professionals from various professions. Therefore, six different professions were involved in surveying these services to appropriately capture the typical time and work involved. Approximately 160 health care professionals completed the surveys for 99366 and 145 completed surveys for 99368, with median annual service performance rates of 30 and 35, respectively.

The HCPAC thoroughly reviewed the specialty societies survey results and recommendations for codes 99366 *Team Conference, health care professionals, patient present* and 99368 *Team Conference, health care professionals, patent not present*. The HCPAC agreed that 99366 would involve slightly more physician work than 99368 because there is more involvement when the patient and/or family is present. The HCPAC concluded that the survey results were flawed because the survey respondents had overestimated physician time due to the key reference service chosen 99242 *Office consultation for a new or established patient* (work RVU=1.34). CPT code 99242 is not a service typically performed by these health care professionals. The reference service poorly compared to the work and time involved to perform these team conference services. The survey resulted in inappropriately high RVUs compared to other health care professional services and there was not appropriate rationale for the health care professionals' recommended work relative value units.

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In order to standardized the time to 30 minutes and properly value these team conference services, the HCPAC then performed a weighted average based on the survey median work values per specialty, with an intra-service time of 30 minutes. The weighted RVU for 99366 was calculated as follows:

Weighted Average for 99366

A	B	C	D	E
HCPAC Society	**Proposed Intra-Service Time / Survey Median Intra-Time**	**Column B x Survey Median Work Value**	**Column C x Percentage of Total Respondents**	**Total**
ASHA	30/35 = 0.86	0.86 x 1.13 = 0.97	0.97 x 28% = 0.27	0.27
ADA	30/45 = 0.66	0.66 x 1.37 = 0.91	0.91 x 24% = 0.22	0.22
APA	30/60 = 0.50	0.50 x 1.25 = 0.63	0.63 x 21% = 0.13	0.13
AOTA	30/52.5 = 0.57	0.57 x 1.20 = 0.68	0.68 x 16% = 0.11	0.11
APTA	30/35 = 0.86	0.86 x 1.10 = 0.94	0.94 x 7% = 0.06	0.06
NASW	30/45 = 0.66	0.66 x 1.30 = 0.86	0.86 x 4% = 0.03	0.03
			Weighted RVU =	**0.82**

The weighted average calculation produced a work relative value of 0.82. The HCPAC determined that a 0.82 work RVU was appropriate when compared to commonly reported codes by other health care professionals such as occupational therapists, physical therapists and dieticians. For example, code 97110 *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* valued at (RVU=0.45) or code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* valued at (RVU=0.37), both which are valued at 15 minute increments. Therefore, if these services are doubled to 30 minutes, for a comparable reference to code 99366, the RVUs equal 0.90 and 0.74 respectively. Thus placing the RVU recommendation of 0.82 for 99366 appropriately relative to similar health care professional services. **The HCPAC recommends a work RVU of 0.82 for code 99366.**

The HCPAC analyzed the survey pre-, intra-, and post-service survey times and determined that these times were too high, relative to similar services performed by health care professionals. The HCPAC compared the surveyed pre/intra/post times to the aforementioned commonly reported codes by other health care professionals, 97110 (2/14/2 minutes) and 97803 (0/15/0 minutes). If these 15 minute timed reference codes are doubled to adequately compare this 30 minute service, the times of 5/30/5 for 99366 and 99368 are appropriate. Additionally, these timed codes state 30 minutes or more in the code descriptor and the HCPAC felt that 30 minutes intra-service time appropriately measured the intensity and complexity involved in performing these services. **The HCPAC recommends a pre-service time of 5 minutes, intra-service time of 30 minutes, and immediate post-service time of 5 minutes for 99366.**

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The HCPAC analyzed the specialty societies survey data for code 99368 *Team Conference, health care professionals, patent not present.* The HCPAC determined to crosswalk the percentage difference of the survey recommended RVU with the final recommended RVU for code 99366 (0.82/1.25) and apply this percentage difference to the survey recommended RVU to establish an appropriate rank order. The resulting work RVU recommendation is 0.72. **The HCPAC recommends a pre-service time of 5 minutes, intra-service time of 30 minutes, and immediate post-service time of 5 minutes for 99368. The HCPAC recommends a work RVU of 0.72 for code 99368.**

Practice Expense

The HCPAC reviewed the practice expense associated with 99366 and determined that typically when a patient is present they are greeted and receive a educational booklet. However, there are at least three health care professionals involved, so the greet time and one booklet are divided by 3 to apportion between providers who will all bill for this service. The HCPAC recommends less than one minute of greeting the patient (0.33 minutes, 1 minute of meet and greet time divided by 3 health care professionals). The HCPAC determined that a blended RN/LPN/MTA clinical labor mix typically provides the greeting. Additionally, the HCPAC recommends 1/3 or 0.33 of a patient education booklet as part of the medical supplies for code 99366. The HCPAC determined that there is no practice expense associated with code 99368.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.~~				
Case management is a process in which a physician or another qualified health care professional is responsible for direct care of a patient and, additionally, for coordinating, managing access to, initiating and/or supervising other healthcare services needed by the patient.				
Medical Team Conferences				
Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (eg, legal guardian) and/or caregivers(s). The participants are actively involved in the development, revision, coordination and implementation of healthcare services needed by the patient. Reporting participants shall have performed face to face evaluations/treatments of the patient, independent of any team conference, within the previous 60 days.				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Reporting participants shall document their participation in the team conference as well as their contributed information and subsequent treatment recommendations. No more than one individual from the same specialty may report 99365-99368 at the same encounter. Individuals should not report when their participation in the medical team conference is part of a facility or organizational service contractually provided by the organizational or facility provider. The team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The reporting participant shall be present for all time reported. The time reported is not limited to the time that the participant is communicating to the other team members or patient and/or family. Time reported for medical team conferences may not be used in the determination of time for other services such as care plan oversight (99374-99380), home, domiciliary or rest home care plan oversight (99339-99340), prolonged services (99354-99359), psychotherapy, or any Evaluation and Management service. For team conferences where the patient is present for any part of the duration of the conference, report the team conference face-to-face codes. (When evaluation and management services are performed separate from the team conference, the appropriate E/M service may be reported with modifier 25)				
D 99361		~~Medical conference by a physician with interdisciplinary team of health professionals or representatives of coummunity agencies to coordinate activities of patient care (patient not present); approximately 30 minutes~~	XXX	
D 99362		~~approximately 60 minutes~~ (99361, 99362 have been deleted. To report, see 99365-99368)	XXX	

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family				
D •99365	C1	~~Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by physician~~	XXX	The CPT Editorial Panel's Executive Committee has deleted this procedure and has revised the introductory language to reflect this deletion
•99366	C2	participation by non-physician qualified health care professional (Team conference services of less than 30 minutes duration are not reported separately)	XXX	0.82
Medical Team Conference, Without Direct (Face-to-Face) Contact With Patient and/or Family				
•99367	C3	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	XXX	1.10 (RUC Recommendation)
•99368	C4	participation by non-physician qualified health care professional (Team conference services of less than 30 minutes duration are not reported separately)	XXX	0.72

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99366 Tracking Number C2 Specialty Society Recommended RVU: **1.34**
Global Period: XXX RUC Recommended RVU: **0.82**

CPT Descriptor: Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Typical Patient - A patient with a neurological disorder, weight loss and functional limitations lives at home with a caregiver. The functional limitations include impaired cognition, mobility, communication and dependencies in basic activities of daily living. The condition is such that the problems and functional limitations are likely to be alleviated with appropriate care and therapies. The optimal care plan needs to be devised in a coordinated manner given the multiple domains requiring attention (biomedical, psychological, social and functional) and multiple healthcare professionals involved in the care of the patient. After undergoing evaluations (each reported separately) by the appropriate disciplines/specialties a team conference is convened.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The non-physician providers gather data and review the patient's chart and other pertinent information to prepare for the team consultation. Documentation and records from the individual provider is also collected and reviewed for the team consultation

Description of Intra-Service Work: The conference is attended by the non-physician and/or physician providers and the patient/patient's family member(s). After discussion, the group devises and approves a plan which includes specified goals, use of medical, nutrition and rehabilitative services and referral to community support services. All participants are engaged in the development, review and formulation of the care plan for the patient. Patient/patient's family member(s) receive educational brochure pertinent to the care plan.

Description of Post-Service Work: A summary report is written and made available to all participants and patient/patient's caregiver but its generation/compilation are reported separately.

Follow-up phone call to the patient/patient's family member(s) to assess understanding and implementation of the patient care plan.

This service does include the individual clinician's post conference creation of documentation of his/her participation in the team conference, including documenting contributed information and treatment recommendations, and review of the care plan for the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007
Presenter(s).	Jane White, PhD, RD, FADA; James Georgoulakis, PhD; Robert C. Fifer, PhD, CCC-A; DorisTomer MSW, LCSW
Specialty(s):	American Dietetic Association; American Occupational Therapy Association; American Physical Therapy Association; American Psychological Association; American Speech, Language, and Hearing Association; National Association of Social Workers
CPT Code:	99366

CPT Code: 99366

Sample Size: 605	Resp N: 159	Response: 26 2 %
Sample Type:		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**30.00**	72 50	2500 00
Survey RVW:	0.00	1.00	**1.25**	1.50	49 50
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	260.00

Immediate Post Service-Time:	20.00	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30), 99231 (20); 99232 (40); 99233 (55), 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40), 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99366		
		Specialty Recommended
Physician Work RVU:		1.34
Pre-Service Evaluation Time:		5.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		30.00
Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99242	XXX	1.34	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99243	XXX	4,897,411	1.88	RUC Time

CPT Descriptor 1 Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Most Recent

MPC CPT Code 2	Global	Medicare Utilization	CPT Code 99366 Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
99374	XXX	1.10	**RUC Time**

CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 49 **% of respondents:** 30.8 %

TIME ESTIMATES (Median)	CPT Code: 99366	Key Reference CPT Code: 99242	Source of Time Harvard Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	30 00	30.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0 0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0 0	0.00	
Median Total Time	**40.00**	**30.00**	
Other time if appropriate		45.00	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.98	3.90
Urgency of medical decision making	3.47	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	4 04	4.02
Physical effort required	2.55	2.55

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.18	3.29
Outcome depends on the skill and judgment of physician	3 98	3.82
Estimated risk of malpractice suit with poor outcome	2.82	2.78

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.12	3.04
Intra-Service intensity/complexity	3 98	3.92
Post-Service intensity/complexity	3.35	3.29

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

After completing a convenience survey among HCPAC (non-physician) society providers (159 responses obtained), an expert panel (including APA, APTA, AOTA, ASHA, NASW and ADA) was convened to review and determine final work RVU recommendations for team conference codes 993699366 and 99368. After noting similarities in the reference service code and work RVU proposed values across all of these societies, the HCPAC societies contacted the physician groups who surveyed the team conference codes 993699365 and 99367 (AAP, APA, AGS and AAPMR) to review and discuss the work RVU recommendations.

While the HCPAC and physician groups have different experiences with completing the AMA work surveys, based on the collective number of survey responses and similar data across all groups, the work RVU data was merged. The HCPAC and physician panel agreed on the survey median work RVU of 1.34 for 99366 and 99365. This decision was based on the expert panel's agreement that the work effort is the same regardless of provider type who participates in the team conference. The 1.34 work RVU for 99366 is further supported based on the HCAPC survey data indicating the service involves 45 minutes intra-service time, longer than many of the intra-services times for codes included on the reference service list.

Additionally, the panel felt 99365 and 99366 include more intense work effort than 99367 and 99368 since the patient and/or family member are present during the team conference. A dynamic, highly engaged conference is required to plan and implement the care plan with the patient and family member(s). In the 99365 and 99366 work effort, the healthcare provider(s) translate clinical information in layman's terms for increased

comprehension by the family/patient, respond to the family/patient questions, incorporate new information from the family/patient into the decision-making process, and adjust the care plan based on new information and family/patient input. All these activities increase the healthcare provider's work effort. The recommended work value is also supported by the complexity of the patient/patient's condition that requires active participation of at least 3 healthcare providers who participate on the team conference.

The expert panel feels the recommended work RVU of 1.34 for team conference codes 99366 and 99365 places these codes in correct rank order with the reference service code (99242; work RVU 1.34) as well as other E/M codes. The panel reviewed E/M codes which represent much less time with the patient- 99214 (work RVU 1.42 for 25 minutes) and 99213 (work RVU = 0.92 for 15 minutes). The panel feels the recommended work value for 99366 and 99365 represents correct rank order based on this E/M code review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99361 however this code does not match the new description of 9936X2

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ADA and ASHA	How often? Commonly
Specialty APTA and AOTA	How often? Commonly
Specialty APA and NASW	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 100000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ADA and ASHA	Frequency 33333	Percentage 33.33 %
Specialty APTA and AOTA	Frequency 33333	Percentage 33.33 %
Specialty APA and NASW	Frequency 33333	Percentage 33.33 %

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99368 Tracking Number C4 Specialty Society Recommended RVU: **1.30**
Global Period: XXX RUC Recommended RVU: **0.72**

CPT Descriptor: Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Typical Patient - A patient with a neurological disorder, weight loss and functional limitations lives at home with a caregiver. The functional limitations include impaired cognition, mobility, communication and dependencies in basic activities of daily living. The condition is such that the problems and functional limitations are likely to be alleviated with appropriate care and therapies. The optimal care plan needs to be devised in a coordinated manner given the multiple domains requiring attention (biomedical, psychological, social and functional) and multiple healthcare professionals involved in the care of the patient. After undergoing evaluations (each reported separately) by the appropriate disciplines/specialties a team conference is convened.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The non-physician providers gather and review the patient's chart and other pertinent information to prepare for the team consultation. Documentation and records from the individual provider is collected and reviewed for the team consultation

Description of Intra-Service Work: The conference is attended by the non-physician and/or physician providers. After presentation of the case, all providers present their findings and recommendations. After discussion, the group devises and approves a plan which includes specified goals, use of medical, nutrition and rehabilitative services and referral to community support services. All participants are engaged in the development, review and formulation of the care plan for the patient.

Description of Post-Service Work: A summary report is written and made available to all participants and patient/patient's family but its generation/compilation are reported separately. A patient brochure regarding the care plan is also provided separately to the patient/patient's family member(s).

Follow-up phone call to the patient/patient's caregiver assess understanding and implementation of the patient care plan.

This service does include the individual clinician's post conference creation of documentation of his/her participation in the team conference, including documenting contributed information and treatment recommendations, and review of the care plan for the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2007
Presenter(s):	Jane White, PhD, RD, FADA; James Georgoulakis, PhD; Robert C. Fifer, PhD, CCC-A; DorisTomer MSW, LCSW
Specialty(s):	American Dietetic Association; American Occupational Therapy Association; American Physical Therapy Association; American Psychological Association; American Speech, Language, and Hearing Association; National Association of Social Workers
CPT Code:	99368

CPT Code: 99368

Sample Size: 602	Resp N: 144	Response: 23.9 %
Sample Type:		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**35.00**	100.00	5800.00
Survey RVW:	0.00	0 99	**1.10**	1 40	46.00
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	20.00	**30.00**	60.00	180 00

Immediate Post Service-Time:	15.00	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	0.0	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit. 99291 (70); 99292 (30); 99231 (20); 99232 (40), 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16), 99213 (23), 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 99368		
		Specialty Recommended
Physician Work RVU:		1.30
Pre-Service Evaluation Time:		5.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		30.00
Immediate Post Service-Time:	5.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service?

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99379	XXX	1.10	RUC Time

CPT Descriptor Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
CPT Descriptor 1				
MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
99242	XXX	1.34	**RUC Time**

CPT Descriptor Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 18.7 %

TIME ESTIMATES (Median)	CPT Code: 99368	Key Reference CPT Code: 99379	Source of Time RUC Time
Median Pre-Service Time	5 00	5.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	5 00	10 00	
Median Critical Care Time	0.0	0 00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**35.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.15	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.81
Urgency of medical decision making	3.11	3.11

Technical Skill/Physical Effort (Mean)

Technical skill required	4.37	4.33
Physical effort required	2.56	2.48

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3 41
Outcome depends on the skill and judgment of physician	4.04	4.00
Estimated risk of malpractice suit with poor outcome	2.85	2 89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 52	3.48
Intra-Service intensity/complexity	3.89	3.85
Post-Service intensity/complexity	3.33	3 30

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

After completing a convenience survey among HCPAC (non-physician) society providers (144 responses obtained), an expert panel (including APA, APTA, AOTA, ASHA, NASW and ADA) was convened to review and determine final work RVU recommendations for team conference codes 99366 and 99368. After noting similarities in the reference service code and work RVU proposed values across all of these societies, the HCPAC societies contacted the physician groups who surveyed the team conference codes 99365 and 99367 (AAP, APA, AGS and AAPMR) to review and discuss the work RVU recommendations.

While the HCPAC and physician groups have different experiences with completing the AMA work surveys, based on the collective number of survey responses and similar data across all groups, the work RVU data was merged. The HCPAC and physician panel agreed on the survey median work RVU of 1.30 for 99368 and 99367. This decision was based on the expert panel's agreement that the work effort is the same regardless of provider type who participates in the team conference.

The 1.30 recommended work value demonstrates rank order between 993899366 and 99368 where 99368 has a lower work RVU since the patient and/or family member are not present during the team conference. Survey data supports the lower value for 99368 with an intra-service time of 30 minutes compared to 99366 intra-service time of 45 minutes.

The HCPAC and physician expert panel feels the recommended work RVU of 1.30 for team conference codes 99368 and 99367 places these codes in correct rank order with other reference service codes that have lower pre-, intra- and post service times (99379 work RVU 1.10, and 99374 work RVU 1.10). Rank order for the proposed 99368 and 99367 RVU of 1.30 is also supported through the expert panels' review of E/M codes 99213 and 99214; both represent less time with the patient (99213 work RVU 0.92 for 15 minutes and 99214 work RVU 1.42 for 25 minutes).

The recommended work value is also supported by the complexity of the patient/patient's condition that requires active participation of at least 3 healthcare providers who participate on the team conference. The conferences are 30 minutes or more, requiring interpretation of the multi-disciplinary clinical findings and spontaneous decision making to formulate the care plan.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99361

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ADA and ASHA	How often? Commonly
Specialty APTA and AOTA	How often? Commonly
Specialty APA and NASW	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 100000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty ADA and ASHA	Frequency 33333	Percentage 33.33 %
Specialty APTA and AOTA	Frequency 33333	Percentage 33.33 %
Specialty APA and NASW	Frequency 33333	Percentage 33.33 %

AMTA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Medical Team Conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional.

An expert consensus panel was used to develop direct practice expense inputs for the team conference code 99366. The expert panel included HCPAC representatives from American Physical Therapy Association; American Psychological Association; American Speech, Language, and Hearing Association and the American Dietetic Association. These groups based their discussions on PE data obtained from the respective group's members.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
None

Intra-Service Clinical Labor Activities:
The clinical staff person greets the patient and/or family member(s) and takes them to the conference room.

Post-Service Clinical Labor Activities:
None.

Supplies: (see PERC spreadsheet)
One patient education booklet

DATE: January 9, 2007

TO: William Rich, MD
Chair, AMA/Specialty Society RVS Update Committee

FROM: The American Occupational Therapy Association; American Physical Therapy Association; American Psychological Association; American Speech, Language, and Hearing Association; National Association of Social Workers, and the American Dietetic Association

Re: Direct Practice Expense Inputs for Code 99368 (team conference code without patient/family member present; Tracking Code C4)

Dear Dr Rich:

Code 99368 (*Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional*) is one of the team conference codes being considered at the February 2007 RUC meeting.

The American Occupational Therapy Association; American Physical Therapy Association; American Psychological Association; American Speech, Language, and Hearing Association; National Association of Social Workers, and the American Dietetic Association convened an expert panel to review direct practice expense for this code, 99368, and 99366. The panel determined there is no direct practice expense for 99368 in either the facility or non-facility setting.

If you have any questions, please contact Pam Michael, MBA, RD, American Dietetic Association staff, at 312-899-4747 or PMichael@eatright.org. Thank you.

	A	B	C	D
1	RUC Practice Expense Recommendation			
2	**Meeting Date. February 2007**			**99366**
3				**Code Descriptor: Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional (assumes 3 providers participate in the team conference)**
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**
5	**GLOBAL PERIOD**			**XXX**
6	**TOTAL CLINICAL LABOR TIME**			**0.33**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.00**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**LO37D**	**RN/LPN/MTA**	**0.33**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.00**
10	**PRE-SERVICE**			
11	**Start: When appointment for service is made**			
12	Review/read X-ray, lab, and pathology reports			
13	Other Clinical Activity (please specify)			
14	**End: Patient arrival at office for service**			
15	**SERVICE PERIOD**			
16	**Start: Patient arrival at office for service**			
17	Greet patient and provide gowning	**LO37D**	**RN/LPN/MTA**	**0.33**
18	Obtain vital signs			
19	Prep and position patient			
20	Prepare room, equipment, supplies			
21	Assist physician during exam			
22	Education/instruction/counseling			
23	Coordinate home or outpatient care			
24	Clean room/equipment			
25	Other Clinical Activity (please specify)			
26	**End: Patient leaves office**			
27	**POST-SERVICE Period**			
28	**Start: Patient leaves office/facility**			
29	Conduct phone calls between visits with patient, family, pharmacy/call in prescriptions			
30	Other activity (please specify)			
31	*Total Office Visit Time*			
32	**End: When appointment for next office visit is made**			
33	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**	
34	Patient education booklet	**SK062**		**0.33**
35				
36				
37	**Equipment**	**CMS Code**	**Utilization Percentage**	
38	None			
39				
40				
41				
42				
43				
44				
45				
46				

Health Care Professionals Advisory Committee
Summary of Recommendations

April 2007

Standardized Cognitive Performance Testing

Prior to 2006, previous CPT code 96115 *Evaluation of Neurobehavioral Status*, was used jointly by neurologists, psychologists, speech-language pathologists, and occupational therapists to assess the orientation, memory, visual-spatial orientation, high-level language function, and other executive function abilities that have been compromised by acute neurological events. Effective January 2006, CPT code 96115 was deleted and replaced with CPT code 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report*, which may only be reported by physicians or psychologists. Consequently, speech-language pathologists and occupational therapists were not able to report this frequently performed procedure. Therefore, in February 2007, the CPT Editorial panel created a new code so that speech-language pathologists, occupational therapists and other health care professionals may report when they are performing a battery of standardized tests evaluating many aspects of neurocognitive functions.

The American Speech-Language-Hearing Association (ASHA) and American Occupational Therapy Association (AOTA), presented work relative value recommendations for 96125 *Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time with the patient and time interpreting test results and preparing the report.* The HCPAC compared 96125 to the survey reference code 96116 *Neurobehavioral status exam, per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU=1.86). Although the survey median work RVU was 1.86 for 96125, the same as reference code 96116, the HCPAC determined that 96125 was not comparable to this reference service and the proposed work RVU was too high. The HCPAC determined that the survey median did not fall within the appropriate range of work RVUs for occupational therapists and speech pathologists and would cause an inter-specialty rank order anomaly.

The HCPAC determined that code 96125 would more appropriately fall between code 97003 *Occupational therapy evaluation* (45 minutes intra-service time, work RVU = 1.20, add an increment of 0.40 RVUs to equal 1 hour, RVU = 1.60) and 97750 *Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes* (work RVU=0.45 x 4 to equal one hour, RVU = 1.80). The HCPAC determined that a work RVU of 1.70 (1.60+1.80/2=1.70) for 96125 would place this service in the appropriate rank order. **The HCPAC recommends a work RVU of 1.70 for code 96125. The HCPAC recommends 7 minutes pre-service time and 60 minutes intra-service time as these times accurately reflect the work performed.**

Practice Expense

The HCPAC reviewed and approved the practice expense inputs of two neurobehavioral status forms for code 96125.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●96125	TT1	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time with the patient and time interpreting test results and preparing the report (For psychological and neuropsychological testing by a physician or psychologist, see codes 96101-96103, 96118-96120)	XXX	1.70

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96125 Tracking Number N/A Specialty Society Recommended RVU: **1.86**
Global Period: XXX RUC Recommended RVU: **1.70**

CPT Descriptor: Standardized cognitive performance testing (eg Ross Information Processing Assessment) per hour of health care professional's time, face-to-face time with the patient with interpretation and written report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36 year old male status post motor vehicle accident with subsequent traumatic brain injury is reffered to the healthcare professional for standardized cognitive performance testing following a recent dischage

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The qualified health care professional reviews pertinent records and selects the tests for administration.

Description of Intra-Service Work: The qualified health care professional selects and completes a face-to-face administration of the appropriate standardized test(s) to examine the patient's current level of functional cognitive performance. Raw and standardized scores are derived and analyzed. A written report is then prepared by the qualified health care professional and sent to the referring physician.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2007					
Presenter(s):	Nancy B. Swigert (ASHA), Terry Moon (AOTA), Doris Tomer (NASW)					
Specialty(s):	Speech-Language Pathology					
CPT Code:	96125					
Sample Size:	567	**Resp N:** 203	**Response:** 35.8 %			
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	5.00	**20.00**	50.00	500.00
Survey RVW:		0.00	1.81	**1.86**	2.39	50.00
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		15.00	60.00	**60.00**	90.00	480.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				

Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**
Prolonged Services:	**0.0**	99354x **0.0** 55x **0.0** 56x **0.0** 57x **0.0**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7), 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

SPECIALTY SOCIETY RECOMMENDED DATA

Check here ☐ if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code: 96125		
		Specialty Recommended
Physician Work RVU:		1.86
Pre-Service Evaluation Time:		7.0
Pre-Service Positioning Time:		0.0
Pre-Service Scrub, Dress, Wait Time:		0.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	0.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.0 99239x 0.0
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0
Prolonged Services:	0.0	99354x 0.0 55x 0.0 56x 0.0 57x 0.0

** See below survey data table on first page.

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96116	XXX	1.86	RUC Time

CPT Descriptor Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Most Recent Medicare Utilization	Work RVU	Time Source
99203	XXX	5,010,000	1.34	RUC Time

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Most Recent Medicare Utilization	Work RVU	Time Source

CPT Code. 96125

99204	XXX	3,002,000	2.3	RUC Time

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Other Reference CPT Code | Global | Work RVU | Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 123 **% of respondents:** 79.8 %

TIME ESTIMATES (Median)

	CPT Code: 96125	Key Reference CPT Code: 96116	Source of Time RUC Time
Median Pre-Service Time	7 00	7 00	
Median Intra-Service Time	60 00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0 0	0.00	
Median Other Hospital Visit Time	0 0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**67.00**	**67.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 67	3.59
Urgency of medical decision making	3 03	2.95

Technical Skill/Physical Effort (Mean)

Technical skill required	4.09	4.01

Physical effort required	2.12	2.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.33	2.29
Outcome depends on the skill and judgment of physician	3.89	3 76
Estimated risk of malpractice suit with poor outcome	2.34	2.34

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.49	2.41
Intra-Service intensity/complexity	4.10	3.95
Post-Service intensity/complexity	3.51	3 38

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code is reported on a per hour basis. The time includes face-to-face time and the time for the interpretation and report. For this reason we are eliminating the median post-service time of 30 minutes reflected on the surveys. This is consistent with the reference code of 96116, Neurobehavioral status examination, which was the code used through 2005 to report by speech language pathologists, occupational therapists and clinical social workers to report this service. In addition, the typical time for performing this service is 2 hours. Thus, we are proposing to allocate the 20 minutes of pre-service time over the 2 units of service which would reduce the pre-service time to 10 minutes. We think the survey median RVW of 1.86 is reasonable in relationship to the reference code and the codes on the MPC list. The IWPUT for this code using 10 minutes of pre time, 60 minutes of intra time and 0 minutes of post time is 0.027.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Under 96115

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty SLP How often? Sometimes

Specialty OT How often? Sometimes

Specialty Social Work How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 75000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. This code is used more in the under-Medicare-age population.

Specialty SLP Frequency 40000 Percentage 53.33 %

Specialty OT Frequency 30000 Percentage 40.00 %

Specialty Social Work Frequency 5000 Percentage 6.66 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 12,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. According to 2004 Medicare data, 4,638 claim lines were billed for occupational therapy services performed under code 96115. CPT 96115 was the 20th of 67 most frequently reported CPT code for speech-language pathology services. The total number of units for 96115 was 2,238.

Specialty SLP Frequency 6500 Percentage 54.16 %

Specialty OT Frequency 5000 Percentage 41.66 %

Specialty Social Work Frequency 500 Percentage 4.16 %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

CPT Code: 96125

AMA/Specialty Society Update Process
PERC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **Standardized cognitive performance testing (eg Ross Information Processing Assessment) per hour of health care professional's time, face-to-face time with the patient with interpretation and written report**

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Practice expense items were determined by an expert consensus panel for the disposable supplies necessary for this procedure. There is no staff time nor is there capital equipment that is to be included as practice expense. The main items of practice expense for this procedure were standardized test forms. It should be noted that the cost of these forms were pro-rated over what we expect to be a typical 2 hour contact.

Please describe the clinical activities of your staff: **N/A**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

	A	B	C	D	E
1					
2	**HCPAC Recommendation**			**96125**	
3	**Meeting Date:04/2007**			**Standardized cognitive performance testing (eg Ross Information Processing Assessment) per hour of health care professional's time, face-to-face time with the patient with interpretation and written report**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**				
6	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms				
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity (please specify)				
18	**End·When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start. When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet patient and provide gowning				
24	Obtain vital signs				
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies				
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV				
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure				
32	**Post-Service**				
33	Monitor pt following service/check tubes, monitors, drains				
34	Clean room/equipment by physician staff				
35	Clean Scope				
36	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions				
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
40	Discharge day management 99238 –12 minutes 99239 --15 minutes				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				
43	**POST-SERVICE Period**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	*Office visits* Greet patient,escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results,assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54					
55	*Total Office Visit Time*			**0**	**0**
56	Other Activity (please specify)				
57	**End. with last office visit before end of global period**				

	A	B	C	D	E
2	**HCPAC Recommendation**			**96125**	
3	**Meeting Date·04/2007**			**Standardized cognitive performance testing (eg Ross Information Processing Assessment) per hour of health care professional's time, face-to-face time with the patient with interpretation and written report**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
58	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
59	Neurobehavioral status forms, average	SK050	Item	**2**	
60					
61					
62					
63					
64					
65					
66	**Equipment**	**CMS Code**	**Utilization Percentage**		
67					
68					
69					