RUC Recommendations for CPT 2010 Volume I

RUC Meetings October 2008, February 2009 and April 2009

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2010

TABLE OF CONTENTS

AMA
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May 27, 2009

Amy Bassano
Director
Hospital and Ambulatory Policy Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Ms. Bassano:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2010*, as well as to existing services identified by the RUC's Five-Year Review Identification Workgroup and CMS. If implemented, the RUC recommendations should result in a positive adjustment to the Medicare conversion factor.

Cost estimates for medical supplies and equipment not listed on the "CMS labor, Supply, and Equipment List for the Year 2010" 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 that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment.

CPT 2010 New and Revised Codes

Enclosed are two binders containing RUC recommendations, including those for new and revised CPT codes. The total number of coding changes for *CPT 2010* is 288, including 119 additions, 128 revisions, and 41 deletions. Twenty-Nine 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. The RUC submits recommendations for 218 new and revised CPT codes. The RUC is recommending that three of these codes be contractor priced in 2010. 121 of the RUC recommendations for new and revised codes initially originated from the Five-Year Review process.

Existing Services Identified by RUC and CMS for Review

The majority of the RUC recommendations for new/revised codes relate to the initial identification of services by the RUC's Five-Year Review Identification Workgroup, followed by action of the CPT Editorial Panel. The *Table of Contents* clearly articulates the category of review for each of the services. In addition, the RUC submits recommendations for 160 services identified by the RUC or CMS as potentially misvalued. The RUC recommends that 87 CPT codes require either modifications to descriptors or clarification within *CPT Assistant.* The work and/or practice expense were reviewed for 65 services. The RUC has recommended that CMS review claims data for seven services and will have no further comment on these codes, unless CMS requests review. Finally, the RUC requests that CMS consider a change in the global period for 66761 *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (1 or more sessions)* from 90 days to 10 days. A summary table of these recommendations is included in the attached binder. Also included in these binders, and on the enclosed CD are:

- RUC Recommendation Status Report for New and Revised Codes
- RUC Recommendation Status Report for more than 500 services identified to date by the Five-Year Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.
- Physician Time File: A list of the physician time data for each of the CPT codes reviewed at the September 2008, February 2009, and April 2009 RUC meetings.
- Pre-Service Time Packages Table: The RUC has recently developed physician pre-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service time data for all codes reviewed by the RUC.
- PLI Crosswalk Table: The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We understand that several of the RUC recommendations for decreased PLI relative values were not implemented in 2009, resulting in $11 million in excess payments for certain services. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.
- New Technology List and Flow Chart – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 139 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.

2012 Five-Year Review Process

The RUC played an instrumental role in the 1997, 2002 and 2007 Five-Year Review processes to review the physician work component of the Resource-Based Relative Value Scale (RBRVS). This review is required according to Section 1848(C)2(B) of the Omnibus Budge Reconciliation Act of 1990, which requires the CMS to comprehensively review all relative values at least every five years and make any needed adjustments. The RUC submits this proposed process, work plan, and timetable for CMS to consider in its planning for this upcoming review.

This proposal will use the framework and ground rules from the previous Five-Year Review to outline a process, work plan, and timeframe for the upcoming Five-Year Review to begin in February 2010 and conclude with the implementation of the values on January 1, 2012. The timeline for this Five-Year Review will be similar to the previous processes. The RUC looks forward to working with CMS in this fourth Five-Year Review of current services in the Physician Payment Schedule.

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

On a personal note, I want to convey my utmost respect and appreciation to the CMS staff that observe our RUC meetings. My term as RUC Chairman concludes on May 31. Doctor Barbara Levy will assume the role on June 1. I know that Doctor Levy will continue to work closely with you to ensure that the RUC recommendations are accepted and implemented by CMS.

Sincerely,

William L. Rich, III, MD, FACS

cc: Cassie Black
Gaysha Brooks
Rick Ensor
Edith Hambrick, MD
Whitney May
Ken Simon, MD
Pam West, DPT
Barbara Levy, MD
RUC participants

Enclosures

AMA/Specialty Society RVS Update Committee

Five-Year Review of the Work Component of the RBRVS
Proposed Process, Work Plan, and Timetable
May 2009

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) played an instrumental role in the 1997, 2002 and 2007 Five-Year Review processes to review the physician work component of the Resource-Based Relative Value Scale (RBRVS). This review is required according to Section 1848(C)2(B) of the Omnibus Budge Reconciliation Act of 1990, which requires the Centers for Medicare and Medicaid Services (CMS) to comprehensively review all relative values at least every five years and make any needed adjustments. CMS is expected to announce the initiation of the 2012 Five-Year Review in the November 2009 *Final Rule* and call for comments on the physician work relative values. The RUC submits this proposed process, work plan, and timetable for CMS to consider in its planning for this upcoming review.

This proposal will use the framework and ground rules from the previous Five-Year review to outline a process, work plan, and timeframe for the upcoming Five-Year Review to begin in February 2010 and conclude with the implementation of the values on January 1, 2012. It should be noted that the time for this Five-Year Review will be similar to the previous processes, as the RUC will have approximately seven months to complete its review.

Historical Overview of Previous Five-Year Review Processes:

On February 23, 1995, the Health Care Financing Administration (HCFA) sent 70 comments on approximately 700 codes to the AMA/Specialty Society RVS Update Committee (RUC) to review and develop specific work relative value unit (RVU) recommendations for submission back to HCFA by September 1995. HCFA also forwarded comments from Medicare Carrier Medical Directors (CMDs) for 300 codes. In addition, large studies from the American Society of Anesthesiology and the American Academy of Orthopaedic Surgeons were sent for review. The American Academy of Pediatrics had also requested more than 1,500 new CPT codes to identify varying levels of work from different age groups. The RUC took on the challenge of reviewing this magnitude of codes and delivered the recommendations to HCFA, on time, seven months after receiving notice of the specific codes to be reviewed.

The RUC accomplished this task by developing a detailed process, work plan, and timetable prior to the submission of the codes to HCFA. The RUC's efforts were successful, as more than 93% of the RUC recommendations were accepted by HCFA, with a greater number accepted after a refinement panel review. Many anomalies in the RBRVS were corrected, including gynecological and neurosurgical services. In addition, the work relative values for the Evaluation and Management services were increased,

both for the individual codes and all of the codes with global surgical periods. The 1997 Five-Year Review did not result in increases for all codes as the RUC also recommended decreases for more than 100 codes.

In the November 2, 1999 *Final Rule*, HCFA announced the second, Five-Year Review (2002) and stated its intention to share comments the agency received with the RUC. HCFA noted that the RUC process used during the 1997 Five-Year Review was "beneficial" and further states:

> *The RUC's perspective will be helpful because of its experience in recommending relative values for codes that have been added to, or revised by, the CPT Editorial panel since we implemented the physician fee schedule in 1992. Furthermore, the RUC, by virtue of its multi-specialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process. We emphasize, however, as we reiterated for the first Five-Year Review, that we retain the responsibility for analyzing the comments in the 2000 physician fee schedule, developing the proposed rule for 2001, evaluating the comments on the proposed rule, and deciding whether to revise relative value units. We are not delegating this responsibility to the RUC or any other organization.*

CMS received only 30 public comments in response to its solicitation of misvalued codes to be reviewed in the second, Five-Year Review. However, 870 codes were identified for review as several specialties (general surgery, vascular surgery and cardiothoracic surgery) commented that nearly all of the services performed by their specialty were misvalued. The process that the RUC utilized in the 2002 Five-Year Review was very similar to the process utilized in the 1997 Five-Year Review. Multidisciplinary workgroups were utilized to review the large number of codes. The entire RUC then reviewed and discussed the reports of these workgroups.

In October 2000, the RUC submitted recommendations to: increase the work relative values for 469 CPT codes; decrease the work relative values for 27 CPT codes; and maintain the work relative values for 311 CPT codes. As in the 1997 Five-Year Review, the RUC also referred 63 codes to the CPT Editorial Panel to consider coding changes. In addition, the RUC reviewed a comment from the American Society of Anesthesiologists that the anesthesia conversion factor was too low. The RUC was able to review a simulated work relative value for 19 anesthesia services and made specific recommendations related to these codes to CMS. The CMS published a Proposed Rule on June 8, 2001, and a Final Rule on November 1, 2001, announcing the agency's intention to accept and implement more than 95% of the RUC's recommendations on January 1, 2002.

In the November 15, 2004, *Final Rule*, CMS solicited comments from the public on misvalued codes. CMS stated that the Agency would also be identifying codes that they

felt were potentially misvalued. The RUC Five-Year Review Compelling Evidence Standards were published in this *Final Rule* and CMS requested that those commenting consider these standards and reference them in their comment letters. As a result of these two processes, CMS received public comments from 44 specialties in response to its solicitation.

In October 2005, February 2006, March 2007 and May 2007 the RUC submitted recommendations on 751 individual CPT codes to CMS. The RUC has recommended improvements to the work RVUs for numerous services including the Evaluation and Management Services, for both stand alone visits and those performed in the post-operative period of surgical procedures. The RUC submitted recommendations to: increase the work relative values for 285 codes; decrease the relative values for 33 codes and maintain the relative values for 294 codes. The RUC also referred 139 codes to the CPT Editorial Panel to consider coding changes prior to consideration of the work relative value.

The third Five-Year Review specifically included review of 35 evaluation and management services and post-induction period procedure anesthesia (PIPPA) intensity. The RUC agreed that incorrect assumptions were made in the previous valuation of E/M services. The RUC recommended and CMS approved an increase in work RVUs for 28 services and maintained the work RVUs for seven services. Furthermore, the RUC recommended and CMS accepted that the full increase of the E/M service be incorporated into the surgical and global periods for each CPT code with global periods of 010 and 090 days.

The RUC considered the request from CMS to assign PIPPA intensity. In addition, CMS referred to the RUC the question of how and whether to apply the E/M Five-Year Review increases to the pre-and post-work of anesthesia services. Based on the extensive review of a building block approach that could be used to evaluate the work of all anesthesia service components other than the post-induction period and validation of PIPPA, the RUC reached agreement that anesthesia services were undervalued by 32%. CMS accepted this recommendation and increased the work of anesthesia services by 32% on January 1, 2008.

In November 2006, CMS published a Final Rule in the Federal Register announcing the agency's final decision regarding these services. CMS accepted 97% of the RUC's recommendations. The relative value changes were implemented on January 1, 2007.

In 2006, the RUC formed the Five-Year Review Identification Workgroup. The purpose of this workgroup is to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review. The Workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of "new technology" services. The Workgroup was established by the RUC following numerous comments from the Medicare Payment Advisory Commission urging CMS to be more diligent in the identification of both

potentially over- and under- valued services within the payment schedule for review during the Five-Year Reviews.

The Five-Year Review Identification Workgroup continues to identify and review services during the interim of each Five-Year Review. The Workgroup's identification screening process to date has addressed services often billed together; fastest growing procedures; services with shifts in the site-of-service; and services with high intensity, relative to other physician services.

Potential Scope of the 2012 Five-Year Review

The scope of the 2012 Five-Year Review is unknown at this time, as CMS comment period will not be initiated until November 2009. AMA RUC staff asked specialty societies to share their intentions regarding the next five-year review. Forty-one specialties responded to this query. Half of the specialties responded that they do not intend on identifying any codes, the other half indicated that as many as 250 CPT codes could be identified. Therefore, it will be prudent, and realistic, to assume that CMS will receive comments on a fair number of codes and a special process will need to be developed to review these codes. Due to the low number of codes anticipated for review, compared to the previous Five-Year Reviews, an additional special meeting in August 2010, may not be necessary. Instead, the entire Five-Year Review could be accomplished at the September 30 - October 3, 2010, RUC meeting, with the possibility of adding one additional day (September 29).

Final Rule Comment Process

In the past, CMS has announced at least a 60 day comment period for the public to identify any misvalued code for review and clarified that the scope of the review will be limited to the work relative values. The practice expense relative values were fully implemented on January 1, 2002, refined and transitioned 2007-2010 and may be further refined by CMS based on the recent Physician Practice Information (PPI) Survey. The professional liability insurance (PLI) relative values were implemented on January 1, 2000, and will be refined for January 1, 2010. The RUC agrees that the 2010 Five-Year Review should be restricted to the review physician work relative values. While it is expected that certain elements of the direct practice expense inputs will be modified due to changes in physician time and/or number of follow-up visits, the RUC considers any independent review of practice expense to be unnecessary at this time.

In the previous comment processes, CMS has stated that their preferred format for submitting a code for review is to include the following:

- CPT code
- Clinical description of the service
- Discussion of how the work of that service is analogous to one or more reference services

- Additional information for services with global periods:
    - physician time - on the same date as the service
    - whether the patient goes home, to a hospital bed, or to an ICU on the same day
    - number, time, type of physician visits after the day of procedure until the end of the global period (distinguish between outpatient and inpatient visits).
    - CMS requests that commenters provide nationally representative data from operating room logs, reports, or medical charts to explain this post-service time.

The RUC has extensively discussed measures to ensure that each specialty society, contractor medical director, or any member of the general public has equal opportunity to comment on misvalued codes and present their argument in a uniform manner. The RUC has developed compelling evidence standards and proposes that these standards be utilized throughout the process. The RUC recommends that the existing work relative value for a code should be considered to be appropriate unless compelling evidence is provided to convince the RUC that the value is either undervalued or overvalued.

These compelling evidence standards have been reviewed by the specialty societies who participate in the RUC process. The RUC believes that these standards should be reviewed by the contractor medical directors and the public prior to their use in the comment period. Therefore, the RUC requests that CMS publish these standards in the *Proposed Rule* this spring and review comments before publishing final compelling evidence standards in the *Final Rule* in November 2009. The RUC envisions that CMS would specify the format of comment letters to include documentation of compelling evidence. The RUC also requests that CMS review and screen comment letters to make sure that they meet the minimal standards regarding compelling evidence prior to sharing with the RUC for review. The comment letter should include a compelling evidence rationale for each code submitted. The compelling evidence standards developed by the RUC are as follows:

Compelling Evidence Standards
The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to CMS, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

    - technique

- knowledge/technology
- patient population
- site-of-service
- length of hospital stay
- physician time

- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

- Evidence that technology has changed physician work (ie, diffusion of technology).

- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

    - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;

    - a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and/or

    - 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.

Timetable

May 2009	Submission of RUC Proposal on Five-Year Review to CMS
December 30, 2009	Comment period closes on public solicitation of codes to be reviewed. *Assumes publication date of CMS Final Rule of November 1, 2009*
February 1, 2010	CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.
February 2010	CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.

February 4-7, 2010	Research Subcommittee to review any changes to the existing RUC survey instrument.
February 16, 2010	AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS.
March 16, 2010	Responses to the LOI due to the AMA.
March 2010	Five-Year Review Workgroup to Review Comment Letters for codes in which there is no interest expressed to determine next steps for the review of these services.
April 28 – May 2, 2010	Summary of codes under review and specialty society assignments Research Subcommittee to review any alternative methodologies introduced.
May 10, 2010	Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.
August 3, 2010*	Recommendations due to the AMA from specialty societies.
August 26-28, 2010*	Five-year review workgroups meet and review recommendations.
September 13, 2010*	Workgroup recommendations and consent calendars sent to the RUC.
September 30 – October 3, 2010	RUC meeting to review workgroup recommendations and consent calendars
October 31, 2010	RUC recommendations submitted to CMS.
November 2010-February 2011	CMS Review
March 2011	Notice of Proposed Rulemaking (NPRM) on Five-Year Review
November 2011	Final Rule on Five-Year Review
January 1, 2012	Implementation of new work relative value units.

**Dates dependent on volume of codes to be reviewed. May only meet Sept/Oct 2010.*

Process, Work Plan, and Policies

Drawing on the ground rules and policies from the previous five-year reviews, the following proposed process should provide the framework for the 2012 Five-Year Review.

CMS Submission and Level of Interest Process

CMS has shared the comments received within three weeks of receipt in all three previous Five-Year Review processes. Therefore, we would request to receive the comments by February 1, 2010. It would also be preferable to receive the comments and list of codes in a similar format as the previous five-year reviews. This format is illustrated in *attachment A*, and included the following fields:

1. CPT Code
2. Short or Medium CPT Descriptor
3. Control Number - linked the code back to a comment letter where the specific comment was identified.
4. Freq – 2008 frequency of claims for the code
5. Commenter - the specialty society or individual commented on the code (a key was provided to define acronyms).
6. Current RVU - the 2010 work RVU would be included here.
7. Rec RVU - the recommended RVU - or a note that the presenter requested an increase or decrease.
8. 1 Ref Code - Code number for a reference code identified
9. 2 Ref Code - Code number for second reference code identified
10. % Dif. - the percentage difference between the work RVU requested and the current work RVU
11. Impact - difference in work RVU x conversion factor x frequency

The inclusion of this information in the material to the RUC was very important and crucial in the compressed schedule to review these services. The RUC will request that CMS follow this same format.

The specialty societies were extremely responsive in the previous five-year reviews in coordinating the Level of Interest process in a few weeks. The same timeframe will be necessary for this five-year review.

Initial Screen of Codes

In 2006, the RUC formed the Five-Year Review Identification Workgroup. The purpose of this workgroup is to identify potentially misvalued services using objective mechanisms for reevaluation prior to the upcoming Five-Year Review. By February 2010, the Five-Year Review Identification Workgroup's identification screening processes will have addressed services often billed together; fastest growing procedures; services with shifts in the site-of-service; and services with high intensity, relative to other physician

services. Therefore, the RUC believes that additional screens are not necessary for the 2010 Five-Year Review.

Although the RUC agreed that an automated screening process is not necessary for the 2010 Five-Year Review, the RUC is also concerned that codes not be excluded from the review if an interest has not been expressed in reviewing the code(s). Therefore, the Five-Year Review Workgroup will convene following the Level of Interest Process to review any codes for which a specialty society has not indicated an interest in involvement to determine the disposition of these comments.

Surveys and Alternative Methodologies

The Research Subcommittee will review the current RUC survey used to develop work RVU recommendations at the February 2010 RUC meeting to determine if any changes need to be incorporated for the Five-Year Review. During the previous Five-Year Reviews, the survey instrument was substantially improved and used for the new and revised code review process after these Five-Year Reviews were completed. However, there may be relevant questions that should be added to the current survey. Such as in the last Five-Year Review in which the question on how the service has changed in past five years was added.

The Research Subcommittee will also be charged with reviewing any alternative methodologies introduced for this Five-Year Review. At this time, it is not known whether any specialty society will be submitting any such study or request the RUC to review a specialty methodology for their services. However, if this does occur, the Research Subcommittee will be prepared to discuss these issues in April and the RUC will determine the appropriateness of any such study/methodology at their April 2010 meeting. Previously approved methodologies are acceptable and will not require a new review by the Research Subcommittee (eg, mini-survey methodology previously utilized by the Society for Vascular Surgery).

The surveys for the Five-Year Review will be mailed to the specialty societies May 10, 2010. As in the past, specialty societies may, if they choose, share their vignettes with the workgroup who will be reviewing their codes to receive feedback prior to the release of their surveys. Copies of all final survey instruments, including vignettes and cover letters, must be provided to the AMA for filing. The completed summary of recommendation forms will be submitted to the AMA RUC staff by August 3, 2010.

Workgroups

The previous Five-Year Review processes incorporated workgroups to review the recommendations. Eight workgroups were utilized with six RUC members or RUC alternate members on each workgroup. For planning purposes, a similar structure will be implemented in the 2012 Five-Year Review process. The assignment of the workgroup

Chairs, composition, and topics to be addressed will be done prior to the April 2010 RUC meeting. The RUC Chair will assign individuals to these workgroups. The workgroups will meet for organizational purposes at the April RUC meeting and for 1 and 1/2 days in August 2010 to review their assigned codes.

If the volume of codes to review in the 2012 Five-Year Review is low, the workgroups will convene for an extra day as part of the Sept/October meeting in lieu of the August 2010 meeting and pre-facilitate all codes.

It should be noted that for services performed only by non-MDs/DOs, the Health Care Professionals Review Board would meet in April and September 2010 to discuss these issues.

Workgroup Rules and Policies

The attached document, *Procedures for August Workgroup and September/October RUC Meetings* was developed to guide the workgroups and to ensure consistency in the rules used by each workgroup. The Workgroup on the Five-Year Review agrees that principles in this document were appropriate and recommends that an update version of this document be forwarded as instructions for the August 2010 workgroup meetings. A few key points from this document are as follows:

- All specialty societies will have equal opportunity to collect and present data to the Workgroup meetings in August 2010. Specialty societies will not be provided with additional opportunity to collect new data following these meetings.

- Following the presentation of each code or issue, the workgroup members will ask questions of the presenters. Time permitting, other RUC members, specialty society advisors, or staff who are present should also feel free to make comments about the codes. The workgroup on the Five-Year Review also recommends that it be explicitly stated that the entire workgroup process will be open to the presenters, and all other RUC participants who wish to attend, including the decision-making process regarding the codes under review.

For each code, the workgroup should attempt to reach consensus on one of the following actions that it will recommend to the RUC:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus
7. Accept withdrawal by commenter, without prejudice

The workgroup may want to suggest a new RVU (action #4) if, for example, it agrees with the commenter and/or specialty society that the RVUs should be increased or decreased, but believes that a different key reference service is more equivalent to the service under review than the one initially presented by the commenter or specialty.

For each of the above actions, the workgroup should have a reason for the action it takes. Recommended increases or decreases should only be adopted if compelling evidence has been provided by either the specialty society or those commenting that the current relative values are incorrect. Rationale must also be provided for referrals the CPT Editorial Panel and for decisions to maintain the current relative values. The only situation in which a detailed discussion and rationale may not be necessary is if the specialty society originally recommended a change and now believes that it has not developed sufficient evidence to support the change and agrees that the current RVUs should be maintained.

Any commenter may withdraw their own comments/codes from the Five-Year Review. In this case, the action key will be recorded as action key #7. Only the original commenter may withdraw a comment/code from the Five-Year Review.

In order to report "no consensus" (action #6) to the RUC, the workgroup or individual(s) who are in the minority must offer a rationale for the lack of consensus. If there is a minority opinion (ie, if five workgroup members believe the specialty's recommendation should be adopted and one member does not) that member must offer some rationale for not adopting the recommendation.

An AMA staff member will attend each workgroup's meeting to record the discussion and decisions at the meeting and draft a report from each group to the RUC. These reports will include the nature of the group discussion, the action taken and rationale for it, and other expressed opinions about the action. Workgroup members will have an (brief) opportunity to review and comment on these drafts before they are disseminated to the full RUC.

- Because preliminary review of the materials is so important, no substitutions for attendance by workgroup members at meetings will be permitted.

RUC Review/Consent Calendar Process

At the September 30 - October 3, 2010 RUC meeting, the recommendations from each workgroup will be presented to the RUC in the form of a consent calendar. There will be five consent calendars for each topic within each workgroup, following each of the first five action keys. Codes for which the workgroup does not reach consensus will be listed individually. During the previous Five-Year Review, there were not significant issues concerning the ability to reach consensus within the workgroups.

The workgroups will meet in executive session to discuss the codes to be extracted, any new information on codes for which they could not reach consensus in August and other issues that may arise between the August and September/October meetings.

Appeals Process

Codes on the consent calendar may be extracted by any RUC member or specialty society advisor who disagrees with the workgroup's recommendation or wishes to have the code discussed by the full RUC. If a RUC member extracts a code for further discussion, the workgroup recommended relative value is the value to be voted upon. However, if a specialty society withdraws a code from the consent calendar and presents its recommendation to the full RUC, the specialty society work value should be the value voted upon. As required by the RUC's Structure and Functions document, a vote by two-thirds of the representatives present at the RUC meeting shall constitute passage of each RVS recommendation.

If a facilitation committee is needed for an issue, the issue will be referred to the same facilitation group to which it was originally assigned. This facilitation committee may be augmented with additional individuals at the request of the specialty society, the workgroup, or the RUC chair.

The RUC also has a formal appeals (re-consideration) process included in the RUC's Rules and Procedures document. This formal appeal would occur after the September/October 2010 RUC meeting and any re-consideration would occur at a future RUC meeting. These appeals process is outlined as follows:

II. **Appeals Process for Reconsideration of RUC Recommendations**

A. If a specialty requests an appeal of a RUC recommendation, the Chair will appoint an Ad Hoc Facilitation Committee as in I.F.1. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.

B. The Ad Hoc Facilitation Committee shall meet in person or by telephone conference within two weeks of receipt of a written request for an appeal.

C. All appeals of RUC decisions shall be in writing.

D. The Ad Hoc Facilitation Committee shall invite appellants to meet with the Ad Hoc Facilitation Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.

E. The Ad Hoc Facilitation Committee will notify anyone who previously commented on an issue under appeal and elicit further comments.

F. The Ad Hoc Facilitation Committee shall vote to recommend to the RUC whether the RUC should reconsider its previous recommendation and, if so, shall develop a new recommendation for consideration by the RUC.

G. The Ad Hoc Facilitation Committee shall provide its recommendation to the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner.

H. An appeal request of a RUC recommendation submitted less than two weeks prior to an upcoming RUC meeting will be deferred to the subsequent RUC meeting to permit at least two weeks notice to all parties.

I. In the event the RUC reconsiders an action by this appeal process, the RUC decision will be final.

J. Approval of reconsideration of a vote which required a two-thirds majority shall itself require a two-thirds majority

Submission to CMS

AMA staff will develop detailed recommendations to be submitted to CMS immediately following the September/October 2010 RUC meeting. These recommendations will be circulated to the RUC for comment prior to their submission to CMS in October 2010.

CMS Review of RUC recommendations

The RUC will request to be invited to any Contractor Medical Director or other committee meetings convened by CMS to review the RUC recommendations. The RUC believes that this participation is necessary to clarify any questions that may arise regarding the RUC recommendations. CMS will publish a *Proposed Rule* in spring of 2011 announcing its review of the RUC's recommendations.

CPT/HCPCS Codes For
2005 Five-Year Review of Work Relative Value Units

CPT Code	Descriptor	Control No.	Freq	Commenter	2005 WRVU	Rec WRVU	Ref 1	Ref 2	Percent Diff.	IMPACT
49010	Exploration behind abdomen	E-61	2,218	ACS	12.26	15.25			24%	$ 251,329
49200	Removal of abdominal lesion	75	3,443	ACOG	10.23	16.14	58952		58%	$ 771,143
49201	Removal abdom lesion, complex	75	3,531	ACOG	14.82	23.38	58952		58%	$ 1,145,466
49505	Prp i/hern init reduc >5 yr	N/A	106,509	CMS	7.59	N/A			N/A	N/A
49906	Free omental flap, microvasc	117	12	ASPS	carrier	(A)			(A)	(A)
50590	Fragmenting of kidney stone	N/A	47,718	CMS	9.08	N/A			N/A	N/A
51720	Treatment of bladder lesion	N/A	210,251	CMS	1.96	N/A			N/A	N/A
51798	Us urine capacity measure	E-43	1,010,865	AUA	0.00	0.38	76857	76942	-----	$ 14,557,517
52000	Cystoscopy	N/A	904,567	CMS	2.01	N/A			N/A	N/A
52204	Cystoscopy	N/A	38,102	CMS	2.37	N/A			N/A	N/A
52601	Prostatectomy (TURP)	N/A	77,404	CMS	12.35	N/A			N/A	N/A
53445	Insert uro/ves nck sphincter	99	2,313	CAPU	14.04	18.87			34%	$ 423,383
54150	Circumcision	104	8	AAP	1.81	(A)			(A)	(A)
54152	Circumcision	104	332	AAP	2.31	(A)			(A)	(A)
54400	Insert semi-rigid prosthesis	99	590	CAPU	8.98	13.81			54%	$ 107,997
54405	Insert multi-comp penis pros	99	5,586	CAPU	13.41	18.24			36%	$ 1,022,489
54411	Remv/replc penis pros, comp	99	218	CAPU	15.98	22.77			42%	$ 56,097
55700	Biopsy of prostate	N/A	241,521	CMS	1.57	N/A			N/A	N/A
56631	Extensive vulva surgery	75	285	ACOG	16.18	18.81	56630	38760	16%	$ 28,406
56632	Extensive vulva surgery	75	250	ACOG	20.26	22.04	56630	38760	9%	$ 16,864
56634	Extensive vulva surgery	75	103	ACOG	17.85	22.92	56633	38760	28%	$ 19,790
56637	Extensive vulva surgery	75	256	ACOG	21.94	26.15	56633	38760	19%	$ 40,844
56640	Extensive vulva surgery	75	29	ACOG	22.14	26.43	56633	38765	19%	$ 4,715
57160	Insert pessary/other device	75	108,198	ACOG	0.89	1.10	99214		24%	$ 861,091
57240	Repair bladder & vagina	75	17,814	ACOG	6.06	10.00	45560		65%	$ 2,659,918
57250	Repair rectum & vagina	75	13,043	ACOG	5.52	10.56	45560		91%	$ 2,491,257
57260	Repair vagina	75	24,634	ACOG	8.26	15.56	57250	57240	88%	$ 6,815,039
57265	Extensive repair of vagina	75	9,611	ACOG	11.32	20.71	57240	57250	83%	$ 3,420,147
57288	Repair bladder defect	N/A	43,945	CMS	13.00	N/A			N/A	N/A
57500	Biopsy of cervix	N/A	9,805	CMS	0.97	N/A			N/A	N/A
57550	Removal of residual cervix	75	49	ACOG	5.52	8.50			54%	$ 5,534
57555	Remove cervix/repair vagina	75	59	ACOG	8.94	19.81	45560	57260	122%	$ 24,305
57556	Remove cervix, repair bowel	75	251	ACOG	8.36	15.07	57283	57550	80%	$ 63,827
58120	Dilation and curettage	N/A	21,596	CMS	3.27	N/A			N/A	N/A
58150	Total hysterectomy	N/A	36,672	CMS	15.22	N/A			N/A	N/A

(A) No WRVU recommendation supplied

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
11040	Debridement, skin, partial thickness	CPT	X							
11041	Debridement, skin, full thickness	CPT	X							
11042	Debridement, skin, and subcutaneous tissue	CPT	X							
11043	Debridement, skin, subcutaneous tissue, and muscle	CPT	X							
11044	Debridement, skin, subcutaneous tissue, muscle, and bone	CPT	X							
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	CPT				X				
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	CPT				X				
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	CPT				X				
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	CPT	X							
20005	Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated	CPT	X							
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection, thoracic	New PE Inputs							X	
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection, lumbar	New PE Inputs	X						X	
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	CPT				X				
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression), cervical below C2	CPT						X		
22849	Reinsertion of spinal fixation device	CPT				X				
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)	CPT				X				
26080	Arthrotomy, with exploration, drainage, or removal of loose or foreign body, interphalangeal joint, each	CPT	X							
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	6.76				X				
27370	Injection procedure for knee arthrography	CPT			X	X				
27640	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia	12.10	X							
27641	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis), fibula	9.72	X							
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	8.08	X							
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	7.56	X							
28725	Arthrodesis; subtalar	11.97	X							
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse,	12.21	X							

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
33213	Insertion or replacement of pacemaker pulse generator only; dual chamber	CPT				X				
35470	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel	CPT				X				
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	CPT				X				
35472	Transluminal balloon angioplasty, percutaneous, aortic	CPT				X				
35473	Transluminal balloon angioplasty, percutaneous, iliac	CPT				X				
35474	Transluminal balloon angioplasty, percutaneous; femoral-popliteal	CPT				X				
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	CPT				X				
35476	Transluminal balloon angioplasty, percutaneous, venous	CPT				X				
35490	Transluminal peripheral atherectomy, percutaneous, renal or other visceral artery	CPT			X					
35491	Transluminal peripheral atherectomy, percutaneous; aortic	CPT			X					
35492	Transluminal peripheral atherectomy, percutaneous; iliac	CPT			X					
35493	Transluminal peripheral atherectomy, percutaneous; femoral-popliteal	CPT			X					
35494	Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel	CPT			X					
35495	Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches	CPT			X					
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	CPT				X				
36481	Percutaneous portal vein catheterization by any method	New PE Inputs							X	
36516	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion	CPT				X				
36825	Creation of arteriovenous fistula by other	15.00	X							
37183	Revision of transvenous intrahepatic	New PE Inputs							X	
42415	Excision of parotid tumor or parotid gland, lateral lobe, with dissection and preservation of facial nerve	17.99	X							
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	20.87	X							
47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	New PE Inputs							X	
47490	Percutaneous cholecystostomy	CPT and recommend 000 day global				X				
49420	Insertion of intraperitoneal cannula or catheter for drainage or dialysis, temporary	CPT	X							
49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis, permanent	CPT	X							
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	9 97	X							
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	12.36	X							
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	7 96	X							
50200	Renal biopsy; percutaneous, by trocar or needle	New PE Inputs							X	
50605	Ureterotomy for insertion of indwelling stent, all types	CPT				X				
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	CPT			X					
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	CPT			X					

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)	13 45							X	
57155	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy	CPT	X							
58555	Hysteroscopy, diagnostic (separate procedure)	New PE inputs							X	
58558	Hysteroscopy, surgical, with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	New PE inputs							X	
58562	Hysteroscopy, surgical, with removal of impacted foreign body	New PE inputs							X	
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	New PE inputs							X	
61795	Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)	CPT				X				
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array	CPT	X							
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment, lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	CPT				X				
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	CPT						X		
64483	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level	CPT				X				
64484	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	CPT				X				
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	New PE inputs							X	
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	PE Review - no change							X	
64555	Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)	CPT			X	X				
64573	Incision for implantation of neurostimulator electrodes; cranial nerve	CPT	X							
64581	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	CPT	X							
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level	PE Review - no change			X	X			X	
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level	PE Reivew - no change			X	X			X	
64712	Neuroplasty, major peripheral nerve, arm or leg, sciatic nerve	CPT	X							
65780	Ocular surface reconstruction, amniotic membrane transplantation	CPT				X				
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (1 or more sessions)	Change to 010-day global		X						
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, ins expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	CPT	X	X		X				

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
69100	Biopsy external ear	0 81				X				
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	CPT				X				
72192	Computed tomography, pelvis; without contrast material	CPT				X				
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	CPT				X		X		
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint, without contrast material(s)	CPT				X				
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation	CPT			X	X				
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	CPT						X		
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	CPT				X				
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	New PE inputs							X	
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	New PE inputs							X	
75992	Transluminal atherectomy, peripheral artery, radiological supervision and interpretation	CPT			X					
75993	Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	CPT			X					
75994	Transluminal atherectomy, renal, radiological supervision and interpretation	CPT			X					
75995	Transluminal atherectomy, visceral, radiological supervision and interpretation	CPT			X					
75996	Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	CPT			X					
76100	Radiologic examination, single plane body section (eg, tomography), other than with urography	New PE inputs							X	
76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography, unilateral	New PE inputs							X	
76102	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	New PE inputs							X	
76513	Ophthalmic ultrasound, diagnostic, anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy	CPT			X					
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	0.56				X				
76970	Ultrasound study follow-up (specify)	CMS to review claims			X					
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	CPT				X				
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session, multi-source Cobalt 60 based	New PE inputs							X	

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	CPT				X				
77427	Radiation treatment management, 5 treatments	CPT	X							
90951	End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits	Revised clinical staff time							X	
90952	with 2-3 face-to-face physician visits per month	Revised clinical staff time							X	
90953	with 1 face-to-face physician visit per month	Revised clinical staff time							X	
90954	End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents, with 4 or more face-to-face physician vi	Revised clinical staff time							X	
90955	with 2-3 face-to-face physician visits per month	Revised clinical staff time							X	
90956	with 1 face-to-face physician visit per month	Revised clinical staff time							X	
90957	End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physici	Revised clinical staff time							X	
90958	with 2-3 face-to-face physician visits per month	Revised clinical staff time							X	
90959	with 1 face-to-face physician visit per month	Revised clinical staff time							X	
90960	End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month	Revised physician and clinical staff time							X	
90961	with 2-3 face-to-face physician visits per month	Revised physician and clinical staff time							X	
90962	with 1 face-to-face physician visit per month	Revised clinical staff time							X	
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	Revised clinical staff time							X	
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	Revised clinical staff time							X	
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	Revised clinical staff time							X	
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over	Revised clinical staff time							X	
92270	Electro-oculography with interpretation and report	CPT			X					
92526	Treatment of swallowing dysfunction and/or oral function for feeding	1 34 work RVU and clinical staff time removed					X			
92587	Evoked otoacoustic emissions, limited (single stimulus level, either transient or distortion products)	CPT				X				

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	1 48 work RVU and clinical staff time removed					X			
92610	Evaluation of oral and pharyngeal swallowing function	1.30 work RVU and clinical staff time removed					X			
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	1 34 work RVU and clinical staff time removed					X			
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	PE Review - no change			X				X	
93230	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis	CPT								X
93233	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout, physician review and interpretation	CPT								X
93307	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording, complete	New PE inputs							X	
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging), complete	New PE inputs							X	
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	New PE inputs							X	
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	CPT						X	X	
93526	Combined right heart catheterization and retrograde left heart catheterization	CPT						X		
93539	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	CPT						X		
93540	Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries	CPT						X		
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	CPT						X	X	
93544	Injection procedure during cardiac catheterization; for aortography	CPT						X		
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	CPT						X	X	
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	CPT						X	X	
93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use	CPT						X	X	

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
93922	Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)	CPT				X				
93923	Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plet	CPT				X				
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study	CPT				X				
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation	CMS to review claims			X					
94015	Patient-initiated spirometric recording per 30-day period of time, recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	CMS to review claims			X					
94016	Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only	CMS to review claims			X					
94450	Breathing response to hypoxia (hypoxia response curve)	CMS to review claims			X					
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	New PE inputs							X	
94761	Noninvasive ear or pulse oximetry for oxygen saturation, multiple determinations (eg, during exercise)	New PE inputs							X	
94762	Noninvasive ear or pulse oximetry for oxygen saturation, by continuous overnight monitoring (separate procedure)	New PE inputs				X			X	
94770	Carbon dioxide, expired gas determination	Should be N/A for Non-Facility PE			X					
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	New PE inputs							X	
95922	Testing of autonomic nervous system function, vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt	CPT			X	X				
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours	CPT				X				
G0179	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period	CPT				X				
G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period	CPT				X				

RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)	CMS to review claims			X	X				
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)	CMS to review claims			X	X				

CPT 2010 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
01632	XXX	D	Oct08	08	Shoulder Joint Anesthesia		Deleted						☑		☐
14300	090	D	Feb09	09	Adjacent Tissue Transfer		Apr09	04	ACS, AAO-HNS, ASPS, AAD				☑	Originated from the Five Year Review	☐
14301	090	N	Feb09	09	Adjacent Tissue Transfer	R1	Apr09	04	ACS, AAO-HNS, ASPS, AAD	12.47	12.47		☑	Originated from the Five Year Review	☐
14302	ZZZ	N	Feb09	09	Adjacent Tissue Transfer	R2	Apr09	04	ACS, AAO-HNS, ASPS, AAD	3.73	3.73		☑	Originated from the Five Year Review	☑
19295	ZZZ	R	Feb09	08	Image Guide Placement - Breast Biopsy		Editorial			0.00	0.00	Yes	☑		☐
21011	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P01	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	2.91	2.91		☑	Originated from the 2005 Five Year Review	☐
21012	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P02	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	4.37	4.37		☑	Originated from the 2005 Five Year Review	☐
21013	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P03	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	5.34	5.34		☑	Originated from the 2005 Five Year Review	☐
21014	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P04	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	7.53	7.00		☑	Originated from the 2005 Five Year Review	☐
21015	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P05	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	9.71	9.71		☑	Originated from the 2005 Five Year Review	☐

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
21016	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P06	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	15.05	15.05		☑	Originated from the 2005 Five Year Review	☐
21552	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P08	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	6.41	6.41		☑	Originated from the 2005 Five Year Review	☐
21554	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P10	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	12.47	11.00		☑	Originated from the 2005 Five Year Review	☐
21555	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P07	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	3.88	3.88		☑	Originated from the 2005 Five Year Review	☐
21556	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P09	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	7.53	7.53		☑	Originated from the 2005 Five Year Review	☐
21557	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P11	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	14.57	14.57		☑	Originated from the 2005 Five Year Review	☐

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
21558	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P12	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	21.37	21.37		☑	Originated from the 2005 Five Year Review	☐
21930	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P13	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	4.86	4.86		☑	Originated from the 2005 Five Year Review	☐
21931	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P14	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	6.80	6.80		☑	Originated from the 2005 Five Year Review	☐
21932	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P15	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	9.71	9.71		☑	Originated from the 2005 Five Year Review	☐
21933	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P16	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	12.63	11.00		☑	Originated from the 2005 Five Year Review	☐
21935	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P17	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	15.54	15.54		☑	Originated from the 2005 Five Year Review	☐
21936	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P18	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	22.34	22.34		☑	Originated from the 2005 Five Year Review	☐

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22900	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P21	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	8.21	8.21		☑	Originated from the 2005 Five Year Review	☐
22901	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P22	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	11.65	10.00		☑	Originated from the 2005 Five Year Review	☐
22902	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P19	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	4.34	4.34		☑	Originated from the 2005 Five Year Review	☐
22903	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P20	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	6.31	6.31		☑	Originated from the 2005 Five Year Review	☐
22904	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P23	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	16.51	16.51		☑	Originated from the 2005 Five Year Review	☐
22905	090	N	Feb08	06	New Excision of Soft Tissue Tumors	P24	Feb09	07	AAOS, AAO-HNS, ACS, ASPS	21.37	21.37		☑	Originated from the 2005 Five Year Review	☐
23071	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P26	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.83	5.83		☑	Originated from the 2005 Five Year Review	☐
23073	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P28	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	10.93	10.00		☑	Originated from the 2005 Five Year Review	☐

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
23075	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P25	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	4.13	4.13		☑	Originated from the 2005 Five Year Review	☐
23076	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P27	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	7.28	7.28		☑	Originated from the 2005 Five Year Review	☐
23077	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P29	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	17.48	17.48		☑	Originated from the 2005 Five Year Review	☐
23078	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P30	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	22.34	22.34		☑	Originated from the 2005 Five Year Review	☐
23200	090	R	Feb08	06	Bone Tumor	P31	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	22.50	22.50		☑	Originated from the 2005 Five Year Review	☐
23210	090	R	Feb08	06	Bone Tumor	P32	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	27.00	27.00		☑	Originated from the 2005 Five Year Review	☐

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23220	090	R	Feb08	06	Bone Tumor	P33	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	30.00	30.00		☑	Originated from the 2005 Five Year Review	☐
23221	090	D	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes		Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS				☑	Originated from the 2005 Five Year Review	☐
23222	090	D	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes		Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS				☑	Originated from the 2005 Five Year Review	☐
24071	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P35	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.62	5.62		☑	Originated from the 2005 Five Year Review	☐
24073	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P37	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	11.30	10.00		☑	Originated from the 2005 Five Year Review	☐
24075	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P34	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	4.16	4.16		☑	Originated from the 2005 Five Year Review	☐

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24076	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P36	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	7.28	7.28		☑	Originated from the 2005 Five Year Review	☐
24077	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P38	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	15.54	15.54		☑	Originated from the 2005 Five Year Review	☐
24079	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P39	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	20.40	20.40		☑	Originated from the 2005 Five Year Review	☐
24150	090	R	Feb08	06	Bone Tumor	P40	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	23.25	23.25		☑	Originated from the 2005 Five Year Review	☐
24151	090	D	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes		Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS				☑	Originated from the 2005 Five Year Review	☐
24152	090	R	Feb08	06	Bone Tumor	P41	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	19.78	19.78		☑	Originated from the 2005 Five Year Review	☐

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24153	090	D	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes		Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS				☑	Originated from the 2005 Five Year Review	☐
25071	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P43	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.83	5.83		☑	Originated from the 2005 Five Year Review	☐
25073	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P45	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	8.26	7.00		☑	Originated from the 2005 Five Year Review	☐
25075	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P42	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	3.88	3.88		☑	Originated from the 2005 Five Year Review	☐
25076	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P44	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	6.61	6.61		☑	Originated from the 2005 Five Year Review	☐
25077	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P46	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	12.75	12.75		☑	Originated from the 2005 Five Year Review	☐

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25078	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P47	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	17.48	17.48		☑	Originated from the 2005 Five Year Review	☐
25170	090	R	Feb08	06	Bone Tumor	P48	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	22.00	22.00		☑	Originated from the 2005 Five Year Review	☐
26111	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P50	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.34	5.34		☑	Originated from the 2005 Five Year Review	☐
26113	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P52	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	7.77	7.00		☑	Originated from the 2005 Five Year Review	☐
26115	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P49	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	3.88	3.88		☑	Originated from the 2005 Five Year Review	☐
26116	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P51	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	6.61	6.61		☑	Originated from the 2005 Five Year Review	☐

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26117	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P53	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	9.95	9.95		☑	Originated from the 2005 Five Year Review	☐
26118	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P54	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	14.57	14.57		☑	Originated from the 2005 Five Year Review	☐
26250	090	R	Feb08	06	Bone Tumor	P55	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	15.00	15.00		☑	Originated from the 2005 Five Year Review	☐
26255	090	D	Feb08	06	Radical Resection of Soft Tissue Tumor Codes		Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH				☑	Originated from the 2005 Five Year Review	☐
26260	090	R	Feb08	06	Bone Tumor	P56	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	11.00	11.00		☑	Originated from the 2005 Five Year Review	☐
26261	090	D	Feb08	06	Radical Resection of Soft Tissue Tumor Codes		Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH				☑	Originated from the 2005 Five Year Review	☐

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
26262	090	R	Feb08	06	Bone Tumor	P57	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	8.13	8.13		☑	Originated from the 2005 Five Year Review	☐
27043	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P59	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	6.80	6.80		☑	Originated from the 2005 Five Year Review	☐
27045	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P61	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	12.63	11.00		☑	Originated from the 2005 Five Year Review	☐
27047	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P58	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	4.86	4.86		☑	Originated from the 2005 Five Year Review	☐
27048	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P60	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	8.74	8.74		☑	Originated from the 2005 Five Year Review	☐
27049	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P62	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	21.37	21.37		☑	Originated from the 2005 Five Year Review	☐

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
27059	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P63	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	29.14	29.14		☑	Originated from the 2005 Five Year Review	☐
27075	090	R	Feb08	06	Bone Tumor	P64	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	32.50	32.50		☑	Originated from the 2005 Five Year Review	☐
27076	090	R	Feb08	06	Bone Tumor	P65	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	40.00	40.00		☑	Originated from the 2005 Five Year Review	☐
27077	090	R	Feb08	06	Bone Tumor	P66	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	45.00	45.00		☑	Originated from the 2005 Five Year Review	☐
27078	090	R	Feb08	06	Bone Tumor	P67	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	32.00	32.00		☑	Originated from the 2005 Five Year Review	☐
27079	090	D	Feb08	06	Radical Resection of Soft Tissue Tumor Codes		Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH				☑	Originated from the 2005 Five Year Review	☐

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
27327	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P68	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	3.88	3.88		☑	Originated from the 2005 Five Year Review	☐
27328	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P70	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	8.74	8.74		☑	Originated from the 2005 Five Year Review	☐
27329	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P72	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	15.54	15.54		☑	Originated from the 2005 Five Year Review	☐
27337	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P69	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.83	5.83		☑	Originated from the 2005 Five Year Review	☐
27339	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P71	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	12.27	11.00		☑	Originated from the 2005 Five Year Review	☐
27364	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P73	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	24.28	24.28		☑	Originated from the 2005 Five Year Review	☐

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27365	090	R	Feb08	06	Bone Tumor	P74	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	32.00	32.00		☑	Originated from the 2005 Five Year Review	☐
27615	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P75	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	15.54	15.54		☑	Originated from the 2005 Five Year Review	☐
27616	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P76	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	19.42	19.42		☑	Originated from the 2005 Five Year Review	☐
27618	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P77	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	3.88	3.88		☑	Originated from the 2005 Five Year Review	☐
27619	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P79	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	6.80	6.80		☑	Originated from the 2005 Five Year Review	☐
27632	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P78	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.83	5.83		☑	Originated from the 2005 Five Year Review	☐

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
27634	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P80	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	10.20	10.00		☑	Originated from the 2005 Five Year Review	☐
27640	090	R	Jun08	07	Partial Excision of Tibia and Fibula		Editorial			12.10	12.10	Yes	☑		☐
27641	090	R	Jun08	07	Partial Excision of Tibia and Fibula		Editorial			9.73	9.73	Yes	☑		☐
27645	090	R	Feb08	06	Bone Tumor	P81	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	27.00	27.00		☑	Originated from the 2005 Five Year Review	☐
27646	090	R	Feb08	06	Bone Tumor	P82	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	23.00	23.00		☑	Originated from the 2005 Five Year Review	☐
27647	090	R	Feb08	06	Bone Tumor	P83	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	20.10	20.10		☑	Originated from the 2005 Five Year Review	☐
28039	090	N	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P87	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	5.34	5.34		☑	Originated from the 2005 Five Year Review	☐
28041	090	N	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P89	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	8.26	7.00		☑	Originated from the 2005 Five Year Review	☐

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
28043	090	R	Feb08	06	Excision of Subcutaneous Soft Tissue Tumor Codes	P86	Feb09	04	AAOS, ACS, AOFAS, ASPS, ASSH, APMA, AAO-HNS	3.88	3.88		☑	Originated from the 2005 Five Year Review	☐
28045	090	R	Feb08	06	Excision of Subfascial Soft Tissue Tumor Codes	P88	Feb09	05	AAOS, ACS, AOFAS, APMA, ASPS, ASSH, AAO-HNS	5.34	5.34		☑	Originated from the 2005 Five Year Review	☐
28046	090	R	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P84	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	12.20	12.20		☑	Originated from the 2005 Five Year Review	☐
28047	090	N	Feb08	06	Radical Resection of Soft Tissue Tumor Codes	P85	Feb09	06	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	17.24	17.24		☑	Originated from the 2005 Five Year Review	☐
28171	090	R	Feb08	06	Bone Tumor	P90	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	16.25	16.25		☑	Originated from the 2005 Five Year Review	☐
28173	090	R	Feb08	06	Bone Tumor	P91	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	14.00	14.00		☑	Originated from the 2005 Five Year Review	☐

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
28175	090	R	Feb08	06	Bone Tumor	P92	Feb09	08	AAOS, AAO-HNS, ACS, AOFAS, APMA, ASPS, ASSH	8.13	8.13		☑	Originated from the 2005 Five Year Review	☐
29220	000	D	Oct08	10	Low Back Strapping		Deleted						☑	Originated from the 2005 Five Year Review	☐
29581	000	N	Feb09	12	Multi-Layer Compression	S1	Apr09	05	SVS, ACS, APMA, APTA	0.60	0.60		☑		☐
30801	010	R	Feb09	13	Turbinoplasty		Editorial			1.11	1.11	Yes	☑		☐
30802	010	R	Feb09	13	Turbinoplasty		Editorial			2.05	2.05	Yes	☑		☐
31622	000	R	Feb09	23	Fiducial Marker Placement		Apr09	06	ACCP/ATS, SIR, ACR	2.78	2.78	Yes	☑		☐
31626	000	N	Feb09	23	Fiducial Marker Placement	T1	Apr09	06	ACCP/ATS, SIR, ACR	4.16	4.16		☑		☑
31627	ZZZ	N	Oct08	11	Navigational Bronchoscopy	E1	Feb09	09	ACCP/ATS	2.00	2.00		☑		☑
32552	010	N	Jun08	08	Tunneled Pleural Catheter Removal	A1	Oct08	05	ACR, SIR, STS	2.50	2.50		☑		☐
32553	000	N	Feb09	23	Fiducial Marker Placement	T2	Apr09	06	ACCP/ATS, SIR, ACR	4.99	3.80		☑		☑
32560	000	R	Feb09	15	Chemical Pleurodesis	U1	Apr09	07	ACCP/ATS, STS	2.78	1.54		☑		☐
32561	000	N	Feb09	15	Chemical Pleurodesis	U2	Apr09	07	ACCP/ATS, STS	2.50	1.39		☑		☐
32562	000	N	Feb09	15	Chemical Pleurodesis	U3	Apr09	07	ACCP/ATS, STS	2.00	1.24		☑		☐
33216	090	R	Feb09	14	Pacing Codes Editorial Revisions		Editorial			5.81	5.81	Yes	☑		☐
33217	090	R	Feb09	14	Pacing Codes Editorial Revisions		Editorial			5.78	5.78	Yes	☑		☐
33223	090	R	Feb09	14	Pacing Codes Editorial Revisions		Editorial			6.49	6.49	Yes	☑		☐
33782	090	N	Jun08	10	Nikaidoh Procedure	B1	Oct09	06	STS	60.00	60.00		☑		☐

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33783	090	N	Jun08	10	Nikaidoh Procedure	B2	Oct09	06	STS	65.00	65.00		☑		☐
33981	XXX	N	Feb09	16	Ventricular Assist Devices	V1	Apr09	08	STS	Contractor Priced	Contractor Priced		☑		☐
33982	XXX	N	Feb09	16	Ventricular Assist Devices	V2	Apr09	08	STS	50.00	Contractor Priced		☑		☐
33983	XXX	N	Feb09	16	Ventricular Assist Devices	V3	Apr09	08	STS	50.00	Contractor Priced		☑		☐
36145	XXX	D	Feb09	31	Arteriovenous Shunt Imaging		Apr09	09	SVS, ACR, SIR				☑	Originated from the Five Year Review	☐
36147	XXX	N	Feb09	31	Arteriovenous Shunt Imaging	W1	Apr09	09	SVS, ACR, SIR	3.85	3.72		☑	Originated from the Five Year Review	☐
36148	ZZZ	N	Feb09	31	Arteriovenous Shunt Imaging	W2	Apr09	09	SVS, ACR, SIR	1.00	1.00		☑	Originated from the Five Year Review	☐
36834	090	D	Feb09	18	Plastic Repair of Aneurysm		Deleted						☑		☐
37760	090	R	Feb09	19	Perforator Vein Ligation		Apr09	10	ACS, SVS	10.69	10.69	Yes	☑	Originated from the Five Year Review	☐
37761	090	N	Feb09	19	Perforator Vein Ligation	X1	Apr09	10	ACS, SVS	9.00	9.00		☑	Originated from the Five Year Review	☐
42894	090	R	Feb09	20	Pharyngeal Wall Resection with Flap	Y1	Apr09	11	AAO-HNS	33.61	33.61	Yes	☑	CPT Clarification, RUC database modification	☐
43273	ZZZ	R	Feb09	EC-R	Endoscopic Pancreatoscopy	AA1	Apr09	13	AGA, ASGE	2.24	2.24	Yes	☑	CPT question regarding inclusion of 43262 in the parenthetical following 43273	☐

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43281	090	N	Feb09	EC-F	Laparoscopic Paraesophageal Hernia Repair	Z1	Apr09	12	ACS, STS, SAGES	26.50	26.50		☑		☑
43282	090	N	Feb09	EC-F	Laparoscopic Paraesophageal Hernia Repair	Z2	Apr09	12	ACS, STS, SAGES	30.00	30.00		☑		☑
43761	000	R	Feb09	08	Gastric Feeding Tube		Editorial			2.01	2.01	Yes	☑		☐
43775	090	N	Feb09	76	Laparoscopic Longitudinal Gastrectomy	BB1	Apr09	14	ACS, SAGES	21.40	21.40		☑		☑
45170	090	D	Oct08	18	Rectal Tumor Excision		Feb09	11	ACS, ASCRS (Colon)				☑	Originated from the Five Year Review	☐
45171	090	N	Oct08	18	Rectal Tumor Excision	G1	Feb09	11	ACS, ASCRS (Colon)	8.00	8.00		☑	Originated from the Five Year Review	☐
45172	090	N	Oct08	18	Rectal Tumor Excision	G2	Feb09	11	ACS, ASCRS (Colon)	12.00	12.00		☑	Originated from the Five Year Review	☐
46200	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			3.48	3.48	Yes	☑		☐
46210	090	D	Feb09	22	Hemorrhoid Code Revision		Deleted						☑		☐
46211	090	D	Feb09	22	Hemorrhoid Code Revision		Deleted						☑		☐
46220	010	R	Feb09	22	Hemorrhoid Code Revision		Editorial			1.58	1.58	Yes	☑		☐
46221	010	R	Feb09	22	Hemorrhoid Code Revision		Editorial			2.31	2.31	Yes	☑		☐
46230	010	R	Feb09	22	Hemorrhoid Code Revision		Editorial			2.59	2.59	Yes	☑		☐
46250	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			4.17	4.17	Yes	☑		☐
46255	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			4.88	4.88	Yes	☑		☐
46257	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			5.68	5.68	Yes	☑		☐

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46258	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			6.28	6.28	Yes	☑		☐
46260	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			6.65	6.65	Yes	☑		☐
46261	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			7.63	7.63	Yes	☑		☐
46262	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			7.80	7.80	Yes	☑		☐
46275	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			5.31	5.31	Yes	☑		☐
46280	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			6.28	6.28	Yes	☑		☐
46320	010	R	Feb09	22	Hemorrhoid Code Revision		Editorial			1.62	1.62	Yes	☑		☐
46707	090	N	Feb09	68	Fistula Plug	CC1	Apr09	15	ASCRS (Colon)	6.30	6.30		☑		☑
46937	010	D	Feb09	22	Hemorrhoid Code Revision		Deleted						☑		☐
46938	090	D	Feb09	22	Hemorrhoid Code Revision		Deleted						☑		☐
46945	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			2.13	2.13	Yes	☑		☐
46946	090	R	Feb09	22	Hemorrhoid Code Revision		Editorial			2.60	2.60	Yes	☑		☐
49411	000	N	Feb09	23	Fiducial Marker Placement	T5	Apr09	06	ACCP/ATS, SIR, ACR	4.59	3.82		☑		☑
51726	000	R	Feb09	24	Urodynamics Studies		Apr09	16	AUA, ACOG	1.71	1.71	Yes	☑	Originated from the Five Year Review	☐
51727	000	N	Feb09	24	Urodynamics Studies	DD1	Apr09	16	AUA, ACOG	2.52	2.11		☑	Originated from the Five Year Review	☐
51728	000	N	Feb09	24	Urodynamics Studies	DD2	Apr09	16	AUA, ACOG	2.48	2.11		☑	Originated from the Five Year Review	☐

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51729	000	N	Feb09	24	Urodynamics Studies	DD3	Apr09	16	AUA, ACOG	3.29	2.51		☑	Originated from the Five Year Review	☐
51772	000	D	Feb09	24	Urodynamics Studies		Apr09	16	AUA, ACOG				☑	Originated from the Five Year Review	☐
51795	000	D	Feb09	24	Urodynamics Studies		Apr09	16	AUA, ACOG				☑	Originated from the Five Year Review	☐
51797	ZZZ	R	Feb09	24	Urodynamics Studies		Apr09	16	AUA, ACOG	0.80	0.80	Yes	☑	Originated from the Five Year Review	☐
52282	000	R	Oct08	41	Temporary Prostatic Urethral Stent Insertion		Feb09	12	AUA	6.39	6.39	Yes	☑		☐
53855	000	N	Oct08	41	Temporary Prostatic Urethral Stent Insertion	H1	Feb09	12	AUA	1.64	1.64		☑		☑
55873	090	R	Oct08	EC-B	Cryosurgical Ablation of the Prostate		Feb09	25	AUA	15.50	13.45		☑		☐
55876	000	R	Feb09	23	Fiducial Marker Placement		Apr09	06	ACCP/ATS, SIR, ACR	1.73	1.73	Yes	☑		☐
57426	090	N	Jun08	11	Laparoscopic Revision of Prosthetic Vaginal Graft	C1	Oct08	07	ACOG	16.23	14.15		☑		☑
63655	090	R	Oct08	19	Neurostimulator (Spinal)		Apr09	17	ISIS, NASS, AANS/CNS, ASA, AAPM	11.43	11.43		☑	Originated from the Five Year Review	☐
63660	090	D	Oct08	19	Neurostimulator (Spinal)		Apr09	17	ISIS, NASS, AANS/CNS, ASA, AAPM				☑	Originated from the Five Year Review	☐

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63661	010	N	Oct08	19	Neurostimulator (Spinal)	I1	Apr09	17	ISIS, NASS, AANS/CNS, ASA, AAPM	5.30	5.03		☑	Originated from the Five Year Review	☐
63662	090	N	Oct08	19	Neurostimulator (Spinal)	I2	Apr09	17	ISIS, NASS, AANS/CNS, ASA, AAPM	10.16	10.87		☑	Originated from the Five Year Review	☐
63663	010	N	Oct08	19	Neurostimulator (Spinal)	I3	Apr09	17	ISIS, NASS, AANS/CNS, ASA, AAPM	8.11	7.70		☑	Originated from the Five Year Review	☐
63664	090	N	Oct08	19	Neurostimulator (Spinal)	I4	Apr09	17	ISIS, NASS, AANS/CNS, ASA, AAPM	12.99	11.36		☑		☐
64470	000	D	Feb09	26	Injection of Anesthetic Agent		Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS				☑		☐
64472	ZZZ	D	Feb09	26	Injection of Anesthetic Agent		Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS				☑		☐
64475	000	D	Feb09	26	Injection of Anesthetic Agent		Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS				☑		☐

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64476	ZZZ	D	Feb09	26	Injection of Anesthetic Agent		Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS				☑		☐
64490	000	N	Feb09	28	Injection of Anesthetic Agent	EE1	Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	2.00	1.82		☐		☐
64491	ZZZ	N	Feb09	28	Injection of Anesthetic Agent	EE2	Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	1.16	1.16		☑		☐
64492	ZZZ	N	Feb09	28	Injection of Anesthetic Agent	EE3	Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	1.16	1.16		☑		☐
64493	000	N	Feb09	28	Injection of Anesthetic Agent	EE4	Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	1.70	1.52		☑		☐
64494	ZZZ	N	Feb09	28	Injection of Anesthetic Agent	EE5	Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	1.00	1.00		☑		☐

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64495	ZZZ	N	Feb09	28	Injection of Anesthetic Agent	EE6	Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	1.00	1.00		☑		☐
72291	XXX	R	Oct08	37	Radiological Supervision and Interpretation - Percutaneous Vertebroplasty		Editorial			0.00	0.00	Yes	☑		☐
72292	XXX	R	Oct08	37	Radiological Supervision and Interpretation - Percutaneous Vertebroplasty		Editorial			0.00	0.00	Yes	☑		☐
74261	XXX	N	Feb09	69	CT Colonography	GG1	Apr09	19	AGA, ACR, ASGE	2.40	2.40		☑		☑
74262	XXX	N	Feb09	69	CT Colonography	GG2	Apr09	19	AGA, ACR, ASGE	2.50	2.50		☑		☑
74263	XXX	N	Feb09	69	CT Colonography	GG3	Apr09	19	AGA, ACR, ASGE	2.28	2.28		☑		☑
75558	XXX	D	Feb09	30	Cardiac MR Velocity Flow		Apr09	20	ACC, ACR				☑		☐
75560	XXX	D	Feb09	30	Cardiac MR Velocity Flow		Apr09	20	ACC, ACR				☑		☐
75562	XXX	D	Feb09	30	Cardiac MR Velocity Flow		Apr09	20	ACC, ACR				☑		☐
75564	XXX	D	Feb09	30	Cardiac MR Velocity Flow		Apr09	20	ACC, ACR				☑		☐
75565	ZZZ	N	Feb09	30	Cardiac MR Velocity Flow	HH1	Apr09	20	ACC, ACR	0.25	0.25		☑		☐
75571	XXX	N	Oct08	42	Coronary Computed Tomographic Angiography	K1	Feb09	15	ACR, ACC	0.70	0.58		☑		☑

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75572	XXX	N	Oct08	42	Coronary Computed Tomographic Angiography	K2	Feb09	15	ACR, ACC	1.75	1.75		☑		☑
75573	XXX	N	Oct08	42	Coronary Computed Tomographic Angiography	K3	Feb09	15	ACR, ACC	2.55	2.55		☑		☑
75574	XXX	N	Oct08	42	Coronary Computed Tomographic Angiography	K4	Feb09	15	ACR, ACC	2.50	2.40		☑		☑
75790	XXX	D	Feb09	31	Arteriovenous Shunt Imaging		Apr09	09	SVS, ACR, SIR				☑	Originated from the Five Year Review	☐
75791	XXX	N	Feb09	31	Arteriovenous Shunt Imaging	W3	Apr09	09	SVS, ACR, SIR	1.84	1.71		☑	Originated from the Five Year Review	☐
77003	XXX	R	Feb09	28	Injection of Anesthetic Agent		Apr09	18	ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	0.60	0.60	Yes	☑		☐
77338	XXX	N	Oct08	21	Multi-Leaf Collimator IMRT Device Use	J1	Feb09	14	ASTRO	4.29	4.29		☑		☐
78451	XXX	N	Oct08	23	Myocardial Perfusion Imaging	L1	Feb09	16	ACR,SNM/ ACNP, ACC	1.50	1.40		☑	Originated from the Five Year Review	☐
78452	XXX	N	Oct08	23	Myocardial Perfusion Imaging	L2	Feb09	16	ACR,SNM/ ACNP, ACC	1.87	1.75		☑	Originated from the Five Year Review	☐
78453	XXX	N	Oct08	23	Myocardial Perfusion Imaging	L3	Feb09	16	ACR,SNM/ ACNP, ACC	1.00	1.00		☑	Originated from the Five Year Review	☐

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78454	XXX	N	Oct08	23	Myocardial Perfusion Imaging	L4	Feb09	16	ACR,SNM/ ACNP, ACC	1.34	1.34		☑	Originated from the Five Year Review	☐
78460	XXX	D	Oct08	23	Myocardial Perfusion Imaging		Feb09	16	ACR,SNM/ ACNP, ACC				☑	Originated from the Five Year Review	☐
78461	XXX	D	Oct08	23	Myocardial Perfusion Imaging		Feb09	16	ACR,SNM/ ACNP, ACC				☑	Originated from the Five Year Review	☐
78464	XXX	D	Oct08	23	Myocardial Perfusion Imaging		Feb09	16	ACR,SNM/ ACNP, ACC				☑	Originated from the Five Year Review	☐
78465	XXX	D	Oct08	23	Myocardial Perfusion Imaging		Feb09	16	ACR,SNM/ ACNP, ACC				☑	Originated from the Five Year Review	☐
78478	XXX	D	Oct08	23	Myocardial Perfusion Imaging		Feb09	16	ACR,SNM/ ACNP, ACC				☑	Originated from the Five Year Review	☐
78480	XXX	D	Oct08	23	Myocardial Perfusion Imaging		Feb09	16	ACR,SNM/ ACNP, ACC				☑	Originated from the Five Year Review	☐
82306	XXX	R	Jun08	14	Vitamin D		CLFS						☐		☐
82307	XXX	D	Jun08	14	Vitamin D		CLFS						☐		☐
82652	XXX	R	Jun08	14	Vitamin D		CLFS						☐		☐
82784	XXX	R	Oct08	24	Gammaglobulin Immunoglobulin Subclasses		CLFS						☐		☐
82785	XXX	R	Oct08	24	Gammaglobulin Immunoglobulin Subclasses		CLFS						☐		☐
82787	XXX	R	Oct08	24	Gammaglobulin Immunoglobulin Subclasses		CLFS						☐		☐

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83516	XXX	R	Feb09	34	Antibodies and Antigens Immunoassay NOS		CLFS						☐		☐
83518	XXX	R	Feb09	34	Antibodies and Antigens Immunoassay NOS		CLFS						☐		☐
83519	XXX	R	Feb09	34	Antibodies and Antigens Immunoassay NOS		CLFS						☐		☐
83520	XXX	R	Feb09	34	Antibodies and Antigens Immunoassay NOS		CLFS						☐		☐
83986	XXX	R	Feb09	72	Exhaled Breath Condensate		CLFS						☐		☐
83987	XXX	N	Feb09	72	Exhaled Breath Condensate		CLFS						☐		☐
84145	XXX	N	Oct08	40	Procalcitonin		CLFS						☐		☐
84431	XXX	N	Feb09	37	Thromboxane Metabolite Measurement		CLFS						☐		☐
86305	XXX	N	Feb09	35	Human Epididymis Protein 4 (HE4)		CLFS						☐		☐
86352	XXX	N	Feb09	38	Immune System Response Cellular Function Assay		CLFS						☐		☐
86592	XXX	R	Oct08	26	Syphillis Screening with Automated Treponemal Assay		CLFS						☐		☐
86593	XXX	N	Oct08	26	Syphillis Screening with Automated Treponemal Assay		CLFS						☐		☐
86780	XXX	N	Oct08	26	Syphillis Screening with Automated Treponemal Assay		CLFS						☐		☐
86781	XXX	D	Oct08	26	Syphillis Screening with Automated Treponemal Assay		CLFS						☐		☐
86825	XXX	N	Feb09	41	Flow Crossmatch Histo Compatability Testing		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
86826	ZZZ	N	Feb09	41	Flow Crossmatch Histo Compatability Testing		CLFS						☐		☐
87149	XXX	R	Feb09	42	Amplified Nucleic Acid Probe Culture Typing		CLFS						☐		☐
87150	XXX	N	Feb09	42	Amplified Nucleic Acid Probe Culture Typing		CLFS						☐		☐
87153	XXX	N	Feb09	43	Microorganism Identification using Sequence Based Information		CLFS						☐		☐
87493	XXX	N	Feb09	43	Clostridium Difficile Amplifed Probe		CLFS						☐		☐
88312	ZZZ	R	May09	04	Special Stains Editorial Revision		Editorial			0.54	0.54	Yes	☐	Will be reviewed in October 2009 as part of the Five Year Review ID Process. Coding changes to clarify add-on status	☐
88313	ZZZ	R	May09	04	Special Stains Editorial Revision		Editorial			0.24	0.24	Yes	☐	Will be reviewed in October 2009 as part of the Five Year Review ID Process. Coding changes to clarify add-on status	☐

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
88314	ZZZ	R	May09	04	Special Stains Editorial Revision		Editorial			0.45	0.45	Yes	☐	Will be reviewed in October 2009 as part of the Five Year Review ID Process. Coding changes to clarify add-on status	☐
88387	XXX	N	Feb09	48	Tissue Examination for Molecular Studies	II1	Apr09	21	CAP	0.62	0.62		☑		☑
88388	ZZZ	N	Feb09	48	Tissue Examination for Molecular Studies	II2	Apr09	21	CAP	0.45	0.45		☑		☑
88738	XXX	N	Oct08	29	Quantitative Transcutaneous Hemoglobin		CLFS						☐		☐
89398	XXX	N	Feb09	49	Unlisted Reproductive Medicine Laboratory Procedure		CLFS						☐		☐
90378	XXX	R	Feb09	51	RSV Monoclonal Antibody		e Globulins/V						☐		☐
90379	XXX	D	Feb09	51	RSV Monoclonal Antibody		e Globulins/V						☐		☐
90669	XXX	R	Oct08	30	Pneumococcoal Conjugate Vaccine		e Globulins/V						☐		☐
90670	XXX	N	Oct08	30	Pneumococcoal Conjugate Vaccine		e Globulins/V						☐		☐
92540	XXX	N	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	1.50	1.50		☑	Originated from the Five Year Review	☐
92541	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.40	0.40	Yes	☑	Originated from the Five Year Review	☐

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
92542	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.33	0.33	Yes	☑	Originated from the Five Year Review	☐
92543	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.10	0.10	Yes	☑	Originated from the Five Year Review	☐
92544	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.26	0.26	Yes	☑	Originated from the Five Year Review	☐
92545	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.23	0.23	Yes	☑	Originated from the Five Year Review	☐
92550	XXX	N	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.45	0.35		☑	Originated from the Five Year Review	☐
92557	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.60	0.60	Yes	☑	Originated from the Five Year Review	☐
92567	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.20	0.20	Yes	☑	Originated from the Five Year Review	☐
92568	XXX	R	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.29	0.29	Yes	☑	Originated from the Five Year Review	☐
92569	XXX	D	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA				☑	Originated from the Five Year Review	☐
92570	XXX	N	Feb09	54	Bundled Audiology Tests		Apr09	22	ASHA, AAN, AAO-HNS, AAA	0.60	0.55		☑	Originated from the Five Year Review	☐
93701	XXX	R	Oct08	33	Peripheral Electrical Bioimpedance		Feb09	17		0.00	0.00		☑		☐
93750	XXX	N	Feb09	16	Ventricular Assist Devices	V4	Apr09	08	STS	1.75	0.92		☑		☐

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
94011	XXX	N	Feb09	58	Infant Pulmonary Function Testing	KK1	Apr09	23	ACCP/ATS, AAP	2.00	2.00		☑		☑
94012	XXX	N	Feb09	58	Infant Pulmonary Function Testing	KK2	Apr09	23	ACCP/ATS, AAP	2.37	3.10		☑		☑
94013	XXX	N	Feb09	58	Infant Pulmonary Function Testing	KK3	Apr09	23	ACCP/ATS, AAP	1.30	0.66		☑		☑
95905	XXX	N	Oct08	05	Nerve Conduction Tests	M1	Feb09	18	AANEM, AACE, AAN, AAFP, ACNS	0.15	0.05		☑		☑
96570	ZZZ	R	Feb09	59	Endoscopic Photodynamic Therapy Application	MM1	Apr09	24	ACCP/ATS, AGA, ASGE, STS, AATS	1.10	1.10	Yes	☑		☐
96571	ZZZ	R	Feb09	59	Endoscopic Photodynamic Therapy Application	MM2	Apr09	24	ACCP/ATS, AGA, ASGE, STS, AATS	0.55	0.55	Yes	☑		☐
99185	XXX	D	Jun08	17	Deletion of Hypothermia		Deleted						☑		☐
99186	XXX	D	Jun08	17	Deletion of Hypothermia		Deleted						☑		☐
99304	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			1.61	1.61	Yes	☑		☐
99305	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			2.30	2.30	Yes	☑		☐
99306	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			3.00	3.00	Yes	☑		☐
99307	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			0.76	0.76	Yes	☑		☐
99308	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			1.16	1.16	Yes	☑		☐
99309	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			1.55	1.55	Yes	☑		☐
99310	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			2.35	2.35	Yes	☑		☐
99318	XXX	R	Oct08	EC-F	Nursing Facility Services		Editorial			1.71	1.71	Yes	☑		☐
99358	XXX	R	Jun08	05	Prolonged Services Revision	D1	Oct08	08	ACP, AGS	2.10	2.10	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
99359	ZZZ	R	Jun08	05	Prolonged Services Revision	D2	Oct08	08	ACP, AGS	1.00	1.00	Yes	☑		☐

Status Report: CMS Requests and Five-Year Review ID WG Issues

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

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

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 13,419

2007 Work RVU: 5 **2009 Work RVU:** 5
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0.00
2007 Fac PE RVU:0 **2009 Fac PE RVU:**0.00

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

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

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

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, SIR, CAP, ACR, ASC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 123,962

2007 Work RVU: 1.27 **2009 Work RVU:** 1.27
2007 NF PE RVU: 2.41 **2009 NF PE RVU:** 2.26
2007 Fac PE RVU:0.4 **2009 Fac PE RVU:**0.43

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

11040 **Debridement; skin, partial thickness**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,151,987

2007 Work RVU: 0.50 **2009 Work RVU:** 0.50
2007 NF PE RVU: 0.56 **2009 NF PE RVU:** 0.62
2007 Fac PE RVU:0.20 **2009 Fac PE RVU:**0.17

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** February 2009 - Under Review Excision-Debride WG

11041 **Debridement; skin, full thickness**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 752,611

2007 Work RVU: 0.60 **2009 Work RVU:** 0.60
2007 NF PE RVU: 0.68 **2009 NF PE RVU:** 0.69
2007 Fac PE RVU:0.30 **2009 Fac PE RVU:**0.22

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** February 2009 - Under Review Excision-Debride WG

11042 **Debridement; skin, and subcutaneous tissue**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,226,131

2007 Work RVU: 0.80 **2009 Work RVU:** 0.80
2007 NF PE RVU: 0.97 **2009 NF PE RVU:** 0.95
2007 Fac PE RVU:0.39 **2009 Fac PE RVU:**0.30

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** February 2009 - Under Review Excision-Debride WG

Status Report: CMS Requests and Five-Year Review ID WG Issues

11043 **Debridement; skin, subcutaneous tissue, and muscle** **Global:** 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 195,499

2007 Work RVU: 3.04 **2009 Work RVU:** 3.04
2007 NF PE RVU: 3.45 **2009 NF PE RVU:** 3.44
2007 Fac PE RVU: 2.62 **2009 Fac PE RVU:** 2.59

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** February 2009 - Under Review Excision-Debride WG

11044 **Debridement; skin, subcutaneous tissue, muscle, and bone** **Global:** 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 53,998

2007 Work RVU: 4.11 **2009 Work RVU:** 4.11
2007 NF PE RVU: 4.58 **2009 NF PE RVU:** 4.75
2007 Fac PE RVU: 3.73 **2009 Fac PE RVU:** 3.65

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** February 2009 - Under Review Excision-Debride WG

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

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2007 Medicare Utilization Data:** 13,270

2007 Work RVU: 1.48 **2009 Work RVU:** 1.48
2007 NF PE RVU: 1.76 **2009 NF PE RVU:** 1.85
2007 Fac PE RVU: 0.66 **2009 Fac PE RVU:** 0.63

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

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

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,274

2007 Work RVU: 1.78 **2009 Work RVU:** 1.78
2007 NF PE RVU: 1.97 **2009 NF PE RVU:** 2.03
2007 Fac PE RVU: 0.81 **2009 Fac PE RVU:** 0.78

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

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

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2007 Medicare Utilization Data:** 11,329

2007 Work RVU: 3.3 **2009 Work RVU:** 3.3
2007 NF PE RVU: 2.38 **2009 NF PE RVU:** 2.61
2007 Fac PE RVU: 1.44 **2009 Fac PE RVU:** 1.44

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

13120 **Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Skin Repair **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2007 Medicare Utilization Data:** 6,615

2007 Work RVU: 3.32 **2009 Work RVU:** 3.32
2007 NF PE RVU: 4.26 **2009 NF PE RVU:** 4.52
2007 Fac PE RVU:2.41 **2009 Fac PE RVU:**2.60

RUC Recommendation: CPT Assistant Article; Review September 2011 **CPT Action? (if applicable):** CPT Assistant

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13121 **Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Skin Repair **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2007 Medicare Utilization Data:** 69,528

2007 Work RVU: 4.36 **2009 Work RVU:** 4.36
2007 NF PE RVU: 5.32 **2009 NF PE RVU:** 6.26
2007 Fac PE RVU:3.02 **2009 Fac PE RVU:**3.51

RUC Recommendation: CPT Assistant Article; Review September 2011 **CPT Action? (if applicable):** CPT Assistant

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13122 **Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Skin Repair **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2007 Medicare Utilization Data:** 13,490

2007 Work RVU: 1.44 **2009 Work RVU:** 1.44
2007 NF PE RVU: 1.48 **2009 NF PE RVU:** 1.41
2007 Fac PE RVU:0.63 **2009 Fac PE RVU:**0.62

RUC Recommendation: CPT Assistant Article; Review September 2011 **CPT Action? (if applicable):** CPT Assistant

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 10,180

2007 Work RVU: 6.83 **2009 Work RVU:** 6.19
2007 NF PE RVU: 8.14 **2009 NF PE RVU:** 8.43
2007 Fac PE RVU:5.63 **2009 Fac PE RVU:**5.74

RUC Recommendation: 6.19 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 7,949

2007 Work RVU: 9.6 **2009 Work RVU:** 8.58
2007 NF PE RVU: 9.86 **2009 NF PE RVU:** 10.38
2007 Fac PE RVU:7.22 **2009 Fac PE RVU:**7.22

RUC Recommendation: 8.58 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 21,691

2007 Work RVU: 7.66 **2009 Work RVU:** 7.02
2007 NF PE RVU: 8.98 **2009 NF PE RVU:** 9.46
2007 Fac PE RVU:6.64 **2009 Fac PE RVU:**6.66

RUC Recommendation: 7.02 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 14,704

2007 Work RVU: 11.18 **2009 Work RVU:** 9.52
2007 NF PE RVU: 10.63 **2009 NF PE RVU:** 11.35
2007 Fac PE RVU:8.41 **2009 Fac PE RVU:**8.16

RUC Recommendation: 9.52 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 83,282

2007 Work RVU: 8.44 **2009 Work RVU:** 8.44
2007 NF PE RVU: 9.17 **2009 NF PE RVU:** 9.92
2007 Fac PE RVU:7.17 **2009 Fac PE RVU:**7.18

RUC Recommendation: 8.44 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 33,476

2007 Work RVU: 12.67 **2009 Work RVU:** 10.63
2007 NF PE RVU: 11.37 **2009 NF PE RVU:** 12.24
2007 Fac PE RVU:8.88 **2009 Fac PE RVU:**8.68

RUC Recommendation: 10.63 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 96,988

2007 Work RVU: 9.07 **2009 Work RVU:** 9.07
2007 NF PE RVU: 9.02 **2009 NF PE RVU:** 9.56
2007 Fac PE RVU:7.39 **2009 Fac PE RVU:**7.40

RUC Recommendation: 9.07 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

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

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 20,945

2007 Work RVU: 13.67 **2009 Work RVU:** 11.25
2007 NF PE RVU: 12.45 **2009 NF PE RVU:** 13.27
2007 Fac PE RVU:9.72 **2009 Fac PE RVU:**9.36

RUC Recommendation: 11.25 **CPT Action? (if applicable):**

14300 **Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area** **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 14,138

2007 Work RVU: 13.26 **2009 Work RVU:** 13.26
2007 NF PE RVU: 11.77 **2009 NF PE RVU:** 13.02
2007 Fac PE RVU:9.28 **2009 Fac PE RVU:**9.58

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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14301 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm** **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

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

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 12.47 **CPT Action? (if applicable):** February 2009

14302 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm; each additional 30 sq cm, or part thereof (List separately in addition to code for primary procedure)** **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

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

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

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

15120 **Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)** **Global:** 090 **Issue:** Autograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 10,532

2007 Work RVU: 10.96 **2009 Work RVU:** 10.96
2007 NF PE RVU: 10.87 **2009 NF PE RVU:** 11.19
2007 Fac PE RVU:7.71 **2009 Fac PE RVU:**7.63

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

15220 **Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less** **Global:** 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,851

2007 Work RVU: 7.95 **2009 Work RVU:** 7.95
2007 NF PE RVU: 9.5 **2009 NF PE RVU:** 10.16
2007 Fac PE RVU:6.69 **2009 Fac PE RVU:**6.80

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 2,550

2007 Work RVU: 3.99 **2009 Work RVU:** 3.99
2007 NF PE RVU: 3.18 **2009 NF PE RVU:** 3.46
2007 Fac PE RVU:2.15 **2009 Fac PE RVU:**2.24

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

15400 **Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children** **Global:** 090 **Issue:** Xenograft **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAO-HNS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,992

2007 Work RVU: 4.38 **2009 Work RVU:** 4.38
2007 NF PE RVU: 4.25 **2009 NF PE RVU:** 4.96
2007 Fac PE RVU:3.95 **2009 Fac PE RVU:**4.02

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

15401 **Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Xenograft **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACS, ASPS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 6,394

2007 Work RVU: 1 **2009 Work RVU:** 1
2007 NF PE RVU: 1.67 **2009 NF PE RVU:** 1.22
2007 Fac PE RVU:0.42 **2009 Fac PE RVU:**0.36

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

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

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 387

2007 Work RVU: 10 **2009 Work RVU:** 10
2007 NF PE RVU: 11.09 **2009 NF PE RVU:** 10.65
2007 Fac PE RVU:6.71 **2009 Fac PE RVU:**6.76

RUC Recommendation: 10.00 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

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

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 684

2007 Work RVU: 9.94 **2009 Work RVU:** 9.94
2007 NF PE RVU: 9.59 **2009 NF PE RVU:** 10.16
2007 Fac PE RVU:6.53 **2009 Fac PE RVU:**7.14

RUC Recommendation: 9.94 **CPT Action? (if applicable):**

15574 **Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,140

2007 Work RVU: 10.52 **2009 Work RVU:** 10.52
2007 NF PE RVU: 10.64 **2009 NF PE RVU:** 10.73
2007 Fac PE RVU:7.6 **2009 Fac PE RVU:**7.57

RUC Recommendation: 10.52 **CPT Action? (if applicable):**

15576 **Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,453

2007 Work RVU: 9.24 **2009 Work RVU:** 9.24
2007 NF PE RVU: 9.74 **2009 NF PE RVU:** 9.78
2007 Fac PE RVU:6.81 **2009 Fac PE RVU:**6.77

RUC Recommendation: 9.24 **CPT Action? (if applicable):**

15732 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)** **Global:** 090 **Issue:** Muscle - Skin Graft **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 11,108

2007 Work RVU: 19.7 **2009 Work RVU:** 19.7
2007 NF PE RVU: 17.27 **2009 NF PE RVU:** 15.70
2007 Fac PE RVU:12.01 **2009 Fac PE RVU:**11.66

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

15740 **Flap; island pedicle** **Global:** 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 28 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 7,057

2007 Work RVU: 11.57 **2009 Work RVU:** 11.57
2007 NF PE RVU: 11.01 **2009 NF PE RVU:** 12.86
2007 Fac PE RVU:8.58 **2009 Fac PE RVU:**9.36

RUC Recommendation: Maintain **CPT Action? (if applicable):** February 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

17106 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm** **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,159

2007 Work RVU: 4.62 **2009 Work RVU:** 3.61
2007 NF PE RVU: 4.63 **2009 NF PE RVU:** 4.63
2007 Fac PE RVU:3.33 **2009 Fac PE RVU:**3.11

RUC Recommendation: 3.61 **CPT Action? (if applicable):**

17107 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm** **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,925

2007 Work RVU: 9.19 **2009 Work RVU:** 4.68
2007 NF PE RVU: 7.24 **2009 NF PE RVU:** 6.13
2007 Fac PE RVU:5.41 **2009 Fac PE RVU:**4.10

RUC Recommendation: 4.68 **CPT Action? (if applicable):**

17108 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm** **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,127

2007 Work RVU: 13.22 **2009 Work RVU:** 6.37
2007 NF PE RVU: 9.34 **2009 NF PE RVU:** 7.61
2007 Fac PE RVU:7.49 **2009 Fac PE RVU:**5.26

RUC Recommendation: 6.37 **CPT Action? (if applicable):**

19020 **Mastotomy with exploration or drainage of abscess, deep** **Global:** 090 **Issue:** Mastotomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,952

2007 Work RVU: 3.74 **2009 Work RVU:** 3.74
2007 NF PE RVU: 6.39 **2009 NF PE RVU:** 6.51
2007 Fac PE RVU:2.76 **2009 Fac PE RVU:**2.96

RUC Recommendation: Remove hospital visits, reduce 99238 to 0.5 **CPT Action? (if applicable):**

19295 **Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Image Guidance **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 102,040

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 2.57 **2009 NF PE RVU:** 2.35
2007 Fac PE RVU:2.02 **2009 Fac PE RVU:**NA

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

19318 **Reduction mammaplasty** **Global:** 090 **Issue:** Mammaplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,127

2007 Work RVU: 15.91 **2009 Work RVU:** 15.91
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.94 **2009 Fac PE RVU:**10.42

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

19357 **Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion** **Global:** 090 **Issue:** Breast Reconstruction **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,923

2007 Work RVU: 20.57 **2009 Work RVU:** 20.57
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:15.69 **2009 Fac PE RVU:**15.64

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

20000 **Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial** **Global:** 010 **Issue:** Incision of Abcess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,429

2007 Work RVU: 2.14 **2009 Work RVU:** 2.14
2007 NF PE RVU: 2.71 **2009 NF PE RVU:** 2.73
2007 Fac PE RVU:1.68 **2009 Fac PE RVU:**1.58

RUC Recommendation: Remove 99238 **CPT Action? (if applicable):**

20005 **Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated** **Global:** 010 **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,955

2007 Work RVU: 3.55 **2009 Work RVU:** 3.55
2007 NF PE RVU: 3.54 **2009 NF PE RVU:** 3.62
2007 Fac PE RVU:2.2 **2009 Fac PE RVU:**2.10

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

20525 **Removal of foreign body in muscle or tendon sheath; deep or complicated** **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,804

2007 Work RVU: 3.51 **2009 Work RVU:** 3.51
2007 NF PE RVU: 8.62 **2009 NF PE RVU:** 7.57
2007 Fac PE RVU:2.52 **2009 Fac PE RVU:**2.35

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

20550 **Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")** **Global:** 000 **Issue:** Tendon Injections **Screen:** CMS Fastest Growing **Complete?** No

Most Recent April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, APMA, ACRh **First Identified:** October 2008 **2007 Medicare Utilization Data:** 786,838

2007 Work RVU: 0.75 **2009 Work RVU:** 0.75
2007 NF PE RVU: 0.69 **2009 NF PE RVU:** 0.65
2007 Fac PE RVU:0.25 **2009 Fac PE RVU:**0.27

RUC Recommendation: Remove from screen. Review again in September 2011 **CPT Action? (if applicable):**

20551 **Injection(s); single tendon origin/insertion** **Global:** 000 **Issue:** Tendon Injections **Screen:** CMS Fastest Growing **Complete?** No

Most Recent April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, APMA, ACRh **First Identified:** October 2008 **2007 Medicare Utilization Data:** 197,342

2007 Work RVU: 0.75 **2009 Work RVU:** 0.75
2007 NF PE RVU: 0.67 **2009 NF PE RVU:** 0.64
2007 Fac PE RVU:0.32 **2009 Fac PE RVU:**0.30

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

20694 **Removal, under anesthesia, of external fixation system** **Global:** 090 **Issue:** External Fixation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,036

2007 Work RVU: 4.2 **2009 Work RVU:** 4.2
2007 NF PE RVU: 6.69 **2009 NF PE RVU:** 5.78
2007 Fac PE RVU:3.92 **2009 Fac PE RVU:**3.70

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

20900 **Bone graft, any donor area; minor or small (eg, dowel or button)** **Global:** 090 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent April 2008 **Tab** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,350

2007 Work RVU: 5.77 **2009 Work RVU:** 3
2007 NF PE RVU: 8.65 **2009 NF PE RVU:** 6.81
2007 Fac PE RVU:5.5 **2009 Fac PE RVU:**3.04

RUC Recommendation: 3.00 **CPT Action? (if applicable):**

20902 **Bone graft, any donor area; major or large** **Global:** 090 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent April 2008 **Tab** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 3,964

2007 Work RVU: 7.98 **2009 Work RVU:** 4.58
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.63 **2009 Fac PE RVU:**3.75

RUC Recommendation: 4.58 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

20926 **Tissue grafts, other (eg, paratenon, fat, dermis)** **Global:** 090 **Issue:** Tissue Grafts **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, AAO-HNS, AANS, APMA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 10,630

2007 Work RVU: 5.7 **2009 Work RVU:** 5.7
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.67 **2009 Fac PE RVU:**4.60

RUC Recommendation: Review October 2009 **CPT Action? (if applicable):**

21015 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS, AAO-HNS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,979

2007 Work RVU: 5.59 **2009 Work RVU:** 5.59
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.85 **2009 Fac PE RVU:**4.56

RUC Recommendation: 9.71 **CPT Action? (if applicable):** June 2008

21025 **Excision of bone (eg, for osteomyelitis or bone abscess); mandible** **Global:** 090 **Issue:** Excision of Bone – Mandible **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 10 **Specialty Developing Recommendation:** AAOMS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,113

2007 Work RVU: 11.07 **2009 Work RVU:** 9.87
2007 NF PE RVU: 12.32 **2009 NF PE RVU:** 11.11
2007 Fac PE RVU:9.21 **2009 Fac PE RVU:**7.88

RUC Recommendation: 9.87 **CPT Action? (if applicable):**

21557 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,812

2007 Work RVU: 8.91 **2009 Work RVU:** 8.91
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.13 **2009 Fac PE RVU:**4.85

RUC Recommendation: 14.57 **CPT Action? (if applicable):** June 2008

21935 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,412

2007 Work RVU: 18.38 **2009 Work RVU:** 18.38
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.37 **2009 Fac PE RVU:**9.02

RUC Recommendation: 15.54 **CPT Action? (if applicable):** June 2008

Status Report: CMS Requests and Five-Year Review ID WG Issues

22214 **Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; lumbar** **Global:** 090 **Issue:** Osteotomy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,725

2007 Work RVU: 20.77 **2009 Work RVU:** 20.77
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:13.53 **2009 Fac PE RVU:**13.22

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

22520 **Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic** **Global:** 010 **Issue:** Moderate Sedation PE Inputs **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASNR, NASS, SIR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 13,978

2007 Work RVU: 9.17 **2009 Work RVU:** 9.17
2007 NF PE RVU: 56.83 **2009 NF PE RVU:** 47.11
2007 Fac PE RVU:4.84 **2009 Fac PE RVU:**4.48

RUC Recommendation: New PE Inputs **CPT Action? (if applicable):** February 2009

22521 **Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar** **Global:** 010 **Issue:** Moderate Sedation PE Inputs **Screen:** Site of Service Anomaly (99238-Only); CMS Request - PE Inputs **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASNR, NASS, SIR **First Identified:** September 2007 **2007 Medicare Utilization Data:** 14,708

2007 Work RVU: 8.6 **2009 Work RVU:** 8.6
2007 NF PE RVU: 52.87 **2009 NF PE RVU:** 46.27
2007 Fac PE RVU:4.69 **2009 Fac PE RVU:**4.28

RUC Recommendation: New PE Inputs **CPT Action? (if applicable):** February 2009

22533 **Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar** **Global:** 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 979

2007 Work RVU: 24.61 **2009 Work RVU:** 24.61
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:13.57 **2009 Fac PE RVU:**13.92

RUC Recommendation: CPT Assistant Article **CPT Action? (if applicable):** SS to draft CPT Asst article by June 2009

22554 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2** **Global:** 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 29,158

2007 Work RVU: 17.54 **2009 Work RVU:** 17.54
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.97 **2009 Fac PE RVU:**11.26

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

22843 **Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 3,012

2007 Work RVU: 13.44 **2009 Work RVU:** 13.44
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.28 **2009 Fac PE RVU:**5.81

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

22849 **Reinsertion of spinal fixation device**

Global: 090 **Issue:** Spinal Fixation **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,417

2007 Work RVU: 19.08 **2009 Work RVU:** 19.08
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.39 **2009 Fac PE RVU:**10.92

RUC Recommendation: Refer to CPT and Review again in September 2011 **CPT Action? (if applicable):** October 2009

22851 **Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intervertebral Device **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 57,852

2007 Work RVU: 6.7 **2009 Work RVU:** 6.7
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.18 **2009 Fac PE RVU:**2.88

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

22900 **Excision, abdominal wall tumor, subfascial (eg, desmoid)**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,942

2007 Work RVU: 6.14 **2009 Work RVU:** 6.14
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.3 **2009 Fac PE RVU:**3.52

RUC Recommendation: 8.21 **CPT Action? (if applicable):** June 2008

23076 **Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,953

2007 Work RVU: 7.77 **2009 Work RVU:** 7.77
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.5 **2009 Fac PE RVU:**5.43

RUC Recommendation: 7.28 **CPT Action? (if applicable):** June 2008

Status Report: CMS Requests and Five-Year Review ID WG Issues

23120 **Claviculectomy; partial** | **Global:** 090 | **Issue:** Claviculectomy | **Screen:** Site of Service Anomaly | **Complete?** Yes

Most Recent RUC Meeting: April 2008 | **Tab** 30 | **Specialty Developing Recommendation:** AAOS | **First Identified:** September 2007 | **2007 Medicare Utilization Data:** 16,099

2007 Work RVU: 7.23 | **2009 Work RVU:** 7.23
2007 NF PE RVU: NA | **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.22 | **2009 Fac PE RVU:**6.16

RUC Recommendation: 7.23 | **CPT Action? (if applicable):**

23130 **Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release** | **Global:** 090 | **Issue:** Removal of Bone | **Screen:** Site of Service Anomaly (99238-Only) | **Complete?** Yes

Most Recent RUC Meeting: September 2007 | **Tab** 16 | **Specialty Developing Recommendation:** AAOS | **First Identified:** September 2007 | **2007 Medicare Utilization Data:** 6,243

2007 Work RVU: 7.63 | **2009 Work RVU:** 7.63
2007 NF PE RVU: NA | **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.88 | **2009 Fac PE RVU:**6.45

RUC Recommendation: Reduce 99238 to 0.5 | **CPT Action? (if applicable):**

23405 **Tenotomy, shoulder area; single tendon** | **Global:** 090 | **Issue:** Tenotomy | **Screen:** Site of Service Anomaly (99238-Only) | **Complete?** Yes

Most Recent RUC Meeting: September 2007 | **Tab** 16 | **Specialty Developing Recommendation:** AAOS | **First Identified:** September 2007 | **2007 Medicare Utilization Data:** 1,667

2007 Work RVU: 8.43 | **2009 Work RVU:** 8.43
2007 NF PE RVU: NA | **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.69 | **2009 Fac PE RVU:**6.32

RUC Recommendation: Reduce 99238 to 0.5 | **CPT Action? (if applicable):**

23410 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute** | **Global:** 090 | **Issue:** Rotator Cuff | **Screen:** Site of Service Anomaly | **Complete?** Yes

Most Recent RUC Meeting: February 2008 | **Tab** 12 | **Specialty Developing Recommendation:** AAOS, AANA | **First Identified:** September 2007 | **2007 Medicare Utilization Data:** 5,152

2007 Work RVU: 12.63 | **2009 Work RVU:** 11.23
2007 NF PE RVU: NA | **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.02 | **2009 Fac PE RVU:**8.17

RUC Recommendation: 11.23 | **CPT Action? (if applicable):**

23412 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic** | **Global:** 090 | **Issue:** Rotator Cuff | **Screen:** Site of Service Anomaly | **Complete?** Yes

Most Recent RUC Meeting: February 2008 | **Tab** 12 | **Specialty Developing Recommendation:** AAOS, AANA | **First Identified:** September 2007 | **2007 Medicare Utilization Data:** 25,677

2007 Work RVU: 13.55 | **2009 Work RVU:** 11.77
2007 NF PE RVU: NA | **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.49 | **2009 Fac PE RVU:**8.47

RUC Recommendation: 11.77 | **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

23415 **Coracoacromial ligament release, with or without acromioplasty** **Global:** 090 **Issue:** Shoulder Ligament Release **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 13 **Specialty Developing Recommendation:** AAOS, AANA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,255

2007 Work RVU: 10.09 **2009 Work RVU:** 9.07
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.65 **2009 Fac PE RVU:**7.13

RUC Recommendation: 9.07 **CPT Action? (if applicable):**

23420 **Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS, AANA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 14,230

2007 Work RVU: 14.75 **2009 Work RVU:** 13.35
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.59 **2009 Fac PE RVU:**9.52

RUC Recommendation: 13.35 **CPT Action? (if applicable):**

23430 **Tenodesis of long tendon of biceps** **Global:** 090 **Issue:** Tenodesis **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,915

2007 Work RVU: 10.05 **2009 Work RVU:** 10.05
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.78 **2009 Fac PE RVU:**7.27

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

23440 **Resection or transplantation of long tendon of biceps** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,680

2007 Work RVU: 10.53 **2009 Work RVU:** 10.53
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.91 **2009 Fac PE RVU:**7.31

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

23472 **Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))** **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 14,934

2007 Work RVU: 22.47 **2009 Work RVU:** 22.47
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:13.89 **2009 Fac PE RVU:**13.15

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

25116 **Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum**

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

Most Recent RUC Meeting: April 2008 **Tab** 31 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,046

2007 Work RVU: 7.38 **2009 Work RVU:** 7.38
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:12.13 **2009 Fac PE RVU:**8.00

RUC Recommendation: 7.38 **CPT Action? (if applicable):**

25210 **Carpectomy; one bone**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,385

2007 Work RVU: 6.01 **2009 Work RVU:** 6.01
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.49 **2009 Fac PE RVU:**5.56

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

25260 **Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 941

2007 Work RVU: 7.89 **2009 Work RVU:** 7.89
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:12.3 **2009 Fac PE RVU:**8.18

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

25280 **Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,308

2007 Work RVU: 7.28 **2009 Work RVU:** 7.28
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.6 **2009 Fac PE RVU:**7.44

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

25310 **Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon**

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

Most Recent RUC Meeting: February 2008 **Tab** 15 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,867

2007 Work RVU: 8.26 **2009 Work RVU:** 7.94
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.99 **2009 Fac PE RVU:**7.97

RUC Recommendation: 7.94 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

26080 **Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each** **Global:** 090 **Issue:** Finger Arthrotomy **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** 16 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,365

2007 Work RVU: 4.36 **2009 Work RVU:** 4.36
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.73 **2009 Fac PE RVU:**4.50

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

26356 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,183

2007 Work RVU: 10.22 **2009 Work RVU:** 10.22
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:17.22 **2009 Fac PE RVU:**14.89

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

26480 **Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon** **Global:** 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2007 Medicare Utilization Data:** 3,002

2007 Work RVU: 6.76 **2009 Work RVU:** 6.76
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:13.68 **2009 Fac PE RVU:**11.02

RUC Recommendation: 6.76 **CPT Action? (if applicable):**

27048 **Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular** **Global:** 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 05 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 954

2007 Work RVU: 6.44 **2009 Work RVU:** 6.44
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.76 **2009 Fac PE RVU:**4.73

RUC Recommendation: 8.74 **CPT Action? (if applicable):** June 2008

27062 **Excision; trochanteric bursa or calcification** **Global:** 090 **Issue:** Trochanteric Bursa Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 32 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,023

2007 Work RVU: 5.66 **2009 Work RVU:** 5.66
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.05 **2009 Fac PE RVU:**4.83

RUC Recommendation: 5.66 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

27244 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 35,400

2007 Work RVU: 17.08 **2009 Work RVU:** 18
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.91 **2009 Fac PE RVU:**10.95

RUC Recommendation: 18.00 **CPT Action? (if applicable):**

27245 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 64,062

2007 Work RVU: 21.09 **2009 Work RVU:** 18
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:13.19 **2009 Fac PE RVU:**11.58

RUC Recommendation: 18.00 **CPT Action? (if applicable):**

27250 **Closed treatment of hip dislocation, traumatic; without anesthesia**

Global: 090 **Issue:** Closed Treatment of Hip Dislocation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 18 **Specialty Developing Recommendation:** ACEP **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,152

2007 Work RVU: 7.21 **2009 Work RVU:** 3.82
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.54 **2009 Fac PE RVU:**1.72

RUC Recommendation: 3.82 **CPT Action? (if applicable):**

27324 **Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)**

Global: 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 997

2007 Work RVU: 4.95 **2009 Work RVU:** 4.95
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.1 **2009 Fac PE RVU:**3.97

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

27370 **Injection procedure for knee arthrography**

Global: 000 **Issue:** Injection for Knee Arthrography **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 13,054

2007 Work RVU: 0.96 **2009 Work RVU:** 0.96
2007 NF PE RVU: 3.47 **2009 NF PE RVU:** 3.14
2007 Fac PE RVU:0.32 **2009 Fac PE RVU:**0.36

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

27615 **Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm** **Global:** 090 **Issue:** Radical Resecion of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,093

2007 Work RVU: 12.93 **2009 Work RVU:** 12.93
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.07 **2009 Fac PE RVU:**7.93

RUC Recommendation: 15.54 **CPT Action? (if applicable):** June 2008

27619 **Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)** **Global:** 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,072

2007 Work RVU: 8.47 **2009 Work RVU:** 8.47
2007 NF PE RVU: 9.65 **2009 NF PE RVU:** 9.76
2007 Fac PE RVU:5.79 **2009 Fac PE RVU:**5.46

RUC Recommendation: 6.80 **CPT Action? (if applicable):** June 2008

27640 **Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia** **Global:** 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,405

2007 Work RVU: 12.1 **2009 Work RVU:** 12.1
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.79 **2009 Fac PE RVU:**8.38

RUC Recommendation: 12.10 **CPT Action? (if applicable):** June 2008

27641 **Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); fibula** **Global:** 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 703

2007 Work RVU: 9.73 **2009 Work RVU:** 9.73
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.96 **2009 Fac PE RVU:**6.72

RUC Recommendation: 9.72 **CPT Action? (if applicable):** June 2008

27650 **Repair, primary, open or percutaneous, ruptured Achilles tendon;** **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,687

2007 Work RVU: 9.94 **2009 Work RVU:** 9
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.22 **2009 Fac PE RVU:**6.90

RUC Recommendation: 9.00 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

27654 **Repair, secondary, Achilles tendon, with or without graft** **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,148

2007 Work RVU: 10.32 **2009 Work RVU:** 10.32
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.86 **2009 Fac PE RVU:**6.86

RUC Recommendation: 10.32 **CPT Action? (if applicable):**

27685 **Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,821

2007 Work RVU: 6.57 **2009 Work RVU:** 6.57
2007 NF PE RVU: 7.68 **2009 NF PE RVU:** 8.31
2007 Fac PE RVU:5.26 **2009 Fac PE RVU:**4.81

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

27687 **Gastrocnemius recession (eg, Strayer procedure)** **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,577

2007 Work RVU: 6.3 **2009 Work RVU:** 6.3
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.12 **2009 Fac PE RVU:**4.70

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,737

2007 Work RVU: 8.96 **2009 Work RVU:** 8.96
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.15 **2009 Fac PE RVU:**6.22

RUC Recommendation: 8.96 **CPT Action? (if applicable):**

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,477

2007 Work RVU: 10.28 **2009 Work RVU:** 10.28
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.51 **2009 Fac PE RVU:**7.48

RUC Recommendation: 10.28 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

27818 **Closed treatment of trimalleolar ankle fracture; with manipulation** **Global:** 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,615

2007 Work RVU: 5.57 **2009 Work RVU:** 5.57
2007 NF PE RVU: 6.14 **2009 NF PE RVU:** 5.61
2007 Fac PE RVU:5 **2009 Fac PE RVU:**4.60

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

28111 **Ostectomy, complete excision; first metatarsal head** **Global:** 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,040

2007 Work RVU: 5.06 **2009 Work RVU:** 5.06
2007 NF PE RVU: 6.55 **2009 NF PE RVU:** 6.83
2007 Fac PE RVU:3.58 **2009 Fac PE RVU:**3.33

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

28118 **Ostectomy, calcaneus;** **Global:** 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,757

2007 Work RVU: 6.02 **2009 Work RVU:** 6.02
2007 NF PE RVU: 6.68 **2009 NF PE RVU:** 7.48
2007 Fac PE RVU:4.28 **2009 Fac PE RVU:**4.15

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

28120 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus** **Global:** 090 **Issue:** Foot Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,708

2007 Work RVU: 5.64 **2009 Work RVU:** 5.64
2007 NF PE RVU: 7.5 **2009 NF PE RVU:** 7.75
2007 Fac PE RVU:4.31 **2009 Fac PE RVU:**4.06

RUC Recommendation: 8.08 **CPT Action? (if applicable):**

28122 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus** **Global:** 090 **Issue:** Foot Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 10,204

2007 Work RVU: 7.56 **2009 Work RVU:** 7.56
2007 NF PE RVU: 7.27 **2009 NF PE RVU:** 7.95
2007 Fac PE RVU:5.17 **2009 Fac PE RVU:**4.89

RUC Recommendation: 7.56 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

28124 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe** **Global:** 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 13,992

2007 Work RVU: 4.88 **2009 Work RVU:** 4.88
2007 NF PE RVU: 5.46 **2009 NF PE RVU:** 6.19
2007 Fac PE RVU:3.62 **2009 Fac PE RVU:**3.47

RUC Recommendation: Remove 99238 **CPT Action? (if applicable):**

28296 **Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)** **Global:** 090 **Issue:** Hallus Valgus Correction **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 23 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 17,881

2007 Work RVU: 9.31 **2009 Work RVU:** 8.16
2007 NF PE RVU: 8.54 **2009 NF PE RVU:** 8.87
2007 Fac PE RVU:5.29 **2009 Fac PE RVU:**5.08

RUC Recommendation: 8.16 **CPT Action? (if applicable):**

28298 **Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy** **Global:** 090 **Issue:** Correction of Bunion **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,105

2007 Work RVU: 8.01 **2009 Work RVU:** 8.01
2007 NF PE RVU: 7.74 **2009 NF PE RVU:** 8.67
2007 Fac PE RVU:4.91 **2009 Fac PE RVU:**4.71

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

28300 **Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation** **Global:** 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,830

2007 Work RVU: 9.61 **2009 Work RVU:** 9.61
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.81 **2009 Fac PE RVU:**6.38

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

28310 **Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)** **Global:** 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,474

2007 Work RVU: 5.48 **2009 Work RVU:** 5.48
2007 NF PE RVU: 6.2 **2009 NF PE RVU:** 6.96
2007 Fac PE RVU:3.53 **2009 Fac PE RVU:**3.43

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

28725 **Arthrodesis; subtalar** **Global:** 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,709

2007 Work RVU: 11.97 **2009 Work RVU:** 11.97
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.93 **2009 Fac PE RVU:**7.21

RUC Recommendation: 11.97 **CPT Action? (if applicable):**

28730 **Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;** **Global:** 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,610

2007 Work RVU: 12.21 **2009 Work RVU:** 12.21
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:8.32 **2009 Fac PE RVU:**8.02

RUC Recommendation: 12.21 **CPT Action? (if applicable):**

28740 **Arthrodesis, midtarsal or tarsometatarsal, single joint** **Global:** 090 **Issue:** Arthrodesis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,792

2007 Work RVU: 9.09 **2009 Work RVU:** 9.09
2007 NF PE RVU: 10.89 **2009 NF PE RVU:** 10.74
2007 Fac PE RVU:6.37 **2009 Fac PE RVU:**6.12

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

28825 **Amputation, toe; interphalangeal joint** **Global:** 090 **Issue:** Toe Amputation at IP Joint **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 37 **Specialty Developing Recommendation:** AOFAS, ACS, APMA, AAOS, SVS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 8,700

2007 Work RVU: 3.71 **2009 Work RVU:** 5.85
2007 NF PE RVU: 7.04 **2009 NF PE RVU:** 7.69
2007 Fac PE RVU:3.4 **2009 Fac PE RVU:**3.95

RUC Recommendation: 5.85 **CPT Action? (if applicable):**

29220 **Strapping; low back** **Global:** 000 **Issue:** Strapping; low back **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAFP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 10,116

2007 Work RVU: 0.64 **2009 Work RVU:** 0.64
2007 NF PE RVU: 0.69 **2009 NF PE RVU:** 0.67
2007 Fac PE RVU:0.38 **2009 Fac PE RVU:**0.39

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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Status Report: CMS Requests and Five-Year Review ID WG Issues

29805 **Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2007 Medicare Utilization Data:** 986

2007 Work RVU: 5.94 **2009 Work RVU:** 5.94
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.44 **2009 Fac PE RVU:**5.04

RUC Recommendation: No NF PE inputs **CPT Action? (if applicable):**

29822 **Arthroscopy, shoulder, surgical; debridement, limited** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 9,097

2007 Work RVU: 7.49 **2009 Work RVU:** 7.49
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.43 **2009 Fac PE RVU:**5.97

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

29827 **Arthroscopy, shoulder, surgical; with rotator cuff repair** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 34,092

2007 Work RVU: 15.44 **2009 Work RVU:** 15.44
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.01 **2009 Fac PE RVU:**10.16

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

29830 **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2007 Medicare Utilization Data:** 21

2007 Work RVU: 5.8 **2009 Work RVU:** 5.8
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.14 **2009 Fac PE RVU:**4.79

RUC Recommendation: No NF PE inputs **CPT Action? (if applicable):**

29840 **Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2007 Medicare Utilization Data:** 76

2007 Work RVU: 5.59 **2009 Work RVU:** 5.59
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.16 **2009 Fac PE RVU:**4.88

RUC Recommendation: No NF PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

29870 **Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2007 Medicare Utilization Data:** 2,022

2007 Work RVU: 5.11 **2009 Work RVU:** 5.11
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.72 **2009 Fac PE RVU:**4.44

RUC Recommendation: Review October 2009 **CPT Action? (if applicable):**

29888 **Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction** **Global:** 090 **Issue:** ACL Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,430

2007 Work RVU: 14.14 **2009 Work RVU:** 14.14
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.75 **2009 Fac PE RVU:**9.23

RUC Recommendation: 14.14 **CPT Action? (if applicable):**

29900 **Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2007 Medicare Utilization Data:** 3

2007 Work RVU: 5.74 **2009 Work RVU:** 5.74
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.6 **2009 Fac PE RVU:**4.97

RUC Recommendation: No NF PE inputs **CPT Action? (if applicable):**

30465 **Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)** **Global:** 090 **Issue:** Repair Nasal Stenosis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,190

2007 Work RVU: 12.2 **2009 Work RVU:** 12.2
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.58 **2009 Fac PE RVU:**11.41

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

31571 **Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope** **Global:** 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,179

2007 Work RVU: 4.26 **2009 Work RVU:** 4.26
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.36 **2009 Fac PE RVU:**2.08

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

31579 **Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy** **Global:** 000 **Issue:** Laryngoscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 36,423

2007 Work RVU: 2.26 **2009 Work RVU:** 2.26
2007 NF PE RVU: 3.5 **2009 NF PE RVU:** 3.10
2007 Fac PE RVU:1.37 **2009 Fac PE RVU:**1.27

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

31611 **Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)** **Global:** 090 **Issue:** Speech Prosthesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 872

2007 Work RVU: 5.92 **2009 Work RVU:** 5.92
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.92 **2009 Fac PE RVU:**7.09

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

32663 **Thoracoscopy, surgical; with lobectomy, total or segmental** **Global:** 090 **Issue:** Thoracoscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** STS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,733

2007 Work RVU: 24.56 **2009 Work RVU:** 24.56
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.44 **2009 Fac PE RVU:**10.23

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

33213 **Insertion or replacement of pacemaker pulse generator only; dual chamber** **Global:** 090 **Issue:** Insertion of Pacemaker **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 44,632

2007 Work RVU: 6.36 **2009 Work RVU:** 6.36
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.87 **2009 Fac PE RVU:**4.11

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):**

33430 **Replacement, mitral valve, with cardiopulmonary bypass** **Global:** 090 **Issue:** Cardiopulmonary Bypass **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 8,815

2007 Work RVU: 50.75 **2009 Work RVU:** 50.75
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:17.71 **2009 Fac PE RVU:**19.31

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

33863 **Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction**

Global: 090 **Issue:** Aortic Graft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,666

2007 Work RVU: 58.71 **2009 Work RVU:** 58.71
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:19.01 **2009 Fac PE RVU:**20.55

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

35470 **Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel**

Global: 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 25,187

2007 Work RVU: 8.62 **2009 Work RVU:** 8.62
2007 NF PE RVU: 81.78 **2009 NF PE RVU:** 66.89
2007 Fac PE RVU:3.37 **2009 Fac PE RVU:**3.53

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

35471 **Transluminal balloon angioplasty, percutaneous; renal or visceral artery**

Global: 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 10.05
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

35472 **Transluminal balloon angioplasty, percutaneous; aortic**

Global: 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 6.90
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

35473 **Transluminal balloon angioplasty, percutaneous; iliac**

Global: 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 6.03
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

35474 **Transluminal balloon angioplasty, percutaneous; femoral-popliteal** **Global:** 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 65,721

2007 Work RVU: 7.35 **2009 Work RVU:** 7.35
2007 NF PE RVU: 80.7 **2009 NF PE RVU:** 66.04
2007 Fac PE RVU:2.9 **2009 Fac PE RVU:**3.05

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

35475 **Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel** **Global:** 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 9.48
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

35476 **Transluminal balloon angioplasty, percutaneous; venous** **Global:** 000 **Issue:** Transluminal Angioplasty **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC, ACR, SIR **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 6.03
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

35490 **Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery** **Global:** 000 **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 100

2007 Work RVU: 11.06 **2009 Work RVU:** 11.06
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.11 **2009 Fac PE RVU:**5.29

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 09-Postponed to Oct 2009

35491 **Transluminal peripheral atherectomy, percutaneous; aortic** **Global:** 000 **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 33

2007 Work RVU: 7.6 **2009 Work RVU:** 7.6
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.46 **2009 Fac PE RVU:**3.19

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 09-Postponed to Oct 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

35492 **Transluminal peripheral atherectomy, percutaneous; iliac** **Global:** 000 **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 576

2007 Work RVU: 6.64 **2009 Work RVU:** 6.64
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.3 **2009 Fac PE RVU:**3.31

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 09-Postponed to Oct 2009

35493 **Transluminal peripheral atherectomy, percutaneous; femoral-popliteal** **Global:** 000 **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 23,892

2007 Work RVU: 8.09 **2009 Work RVU:** 8.09
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.89 **2009 Fac PE RVU:**4.01

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 09-Postponed to Oct 2009

35494 **Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel** **Global:** 000 **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 253

2007 Work RVU: 10.42 **2009 Work RVU:** 10.42
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.64 **2009 Fac PE RVU:**5.00

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 09-Postponed to Oct 2009

35495 **Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches** **Global:** 000 **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 12,067

2007 Work RVU: 9.48 **2009 Work RVU:** 9.48
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.45 **2009 Fac PE RVU:**4.51

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 09-Postponed to Oct 2009

36145 **Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)** **Global:** XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 254,702

2007 Work RVU: 2.01 **2009 Work RVU:** 2.01
2007 NF PE RVU: 11.87 **2009 NF PE RVU:** 10.81
2007 Fac PE RVU:0.64 **2009 Fac PE RVU:**0.69

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** Feb 09-Deleted

Status Report: CMS Requests and Five-Year Review ID WG Issues

36147 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial acess, with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**

Global: XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 09 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 3.72 **CPT Action? (if applicable):** October 2008

36148 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention**

Global: XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 09 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.00 **CPT Action? (if applicable):** October 2008

36248 **Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Catheter Placement **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 22,331

2007 Work RVU: 1.01 **2009 Work RVU:** 1.01
2007 NF PE RVU: 3.81 **2009 NF PE RVU:** 3.36
2007 Fac PE RVU: 0.35 **2009 Fac PE RVU:** 0.39

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

36481 **Percutaneous portal vein catheterization by any method**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2007 Medicare Utilization Data:** 1,001

2007 Work RVU: 6.98 **2009 Work RVU:** 6.98
2007 NF PE RVU: NA **2009 NF PE RVU:** 3.83
2007 Fac PE RVU: 2.46 **2009 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

36516 **Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion** **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACP, ASH **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,018

2007 Work RVU: 1.22 **2009 Work RVU:** 1.22
2007 NF PE RVU: 75.37 **2009 NF PE RVU:** 56.63
2007 Fac PE RVU:0.46 **2009 Fac PE RVU:**0.41

RUC Recommendation: CPT Assistant Article **CPT Action? (if applicable):** CPT Assistant - Aug 2009

36820 **Arteriovenous anastomosis, open; by forearm vein transposition** **Global:** 090 **Issue:** Arteriovenous Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 27 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,709

2007 Work RVU: 14.39 **2009 Work RVU:** 14.39
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.11 **2009 Fac PE RVU:**5.71

RUC Recommendation: 14.39 **CPT Action? (if applicable):**

36821 **Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)** **Global:** 090 **Issue:** Arteriovenous Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 39 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 34,649

2007 Work RVU: 9.15 **2009 Work RVU:** 12
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.49 **2009 Fac PE RVU:**4.96

RUC Recommendation: 12.00 **CPT Action? (if applicable):**

36825 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft** **Global:** 090 **Issue:** Arteriovenous Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 22 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,401

2007 Work RVU: 10 **2009 Work RVU:** 10
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.87 **2009 Fac PE RVU:**4.56

RUC Recommendation: 15.00 **CPT Action? (if applicable):**

36834 **Plastic repair of arteriovenous aneurysm (separate procedure)** **Global:** 090 **Issue:** Aneurysm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AVA, ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,942

2007 Work RVU: 11.11 **2009 Work RVU:** 11.11
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.68 **2009 Fac PE RVU:**4.50

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** February 2009 - Deleted

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Status Report: CMS Requests and Five-Year Review ID WG Issues

36870 **Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2007 Medicare Utilization Data:** 51,491

2007 Work RVU: 5.17 **2009 Work RVU:** 5.17
2007 NF PE RVU: 49.54 **2009 NF PE RVU:** 43.62
2007 Fac PE RVU:2.99 **2009 Fac PE RVU:**2.94

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

37183 **Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2007 Medicare Utilization Data:** 584

2007 Work RVU: 7.99 **2009 Work RVU:** 7.99
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.89 **2009 Fac PE RVU:**3.32

RUC Recommendation: PE Recommendations **CPT Action? (if applicable):**

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 22,432

2007 Work RVU: 3.02 **2009 Work RVU:** 3.02
2007 NF PE RVU: 4.43 **2009 NF PE RVU:** 4.27
2007 Fac PE RVU:1.93 **2009 Fac PE RVU:**1.89

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

37760 **Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open**

Global: 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,777

2007 Work RVU: 10.69 **2009 Work RVU:** 10.69
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.14 **2009 Fac PE RVU:**4.87

RUC Recommendation: 10.69 **CPT Action? (if applicable):** February 2009

37761 **Ligation of perforator vein(s), subfascial, open, includes ultrasound guidance, when performed; one leg**

Global: 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 9.00 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

37765 **Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions** **Global:** 090 **Issue:** Stab Phlebectomy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 10,055

2007 Work RVU: 7.63 **2009 Work RVU:** 7.63
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.36 **2009 Fac PE RVU:**3.93

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

37766 **Stab phlebectomy of varicose veins, one extremity; more than 20 incisions** **Global:** 090 **Issue:** Stab Phlebectomy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 6,417

2007 Work RVU: 9.58 **2009 Work RVU:** 9.58
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.01 **2009 Fac PE RVU:**4.54

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

37785 **Ligation, division, and/or excision of varicose vein cluster(s), one leg** **Global:** 090 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,896

2007 Work RVU: 3.87 **2009 Work RVU:** 3.87
2007 NF PE RVU: 5.12 **2009 NF PE RVU:** 4.96
2007 Fac PE RVU:2.69 **2009 Fac PE RVU:**2.63

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

38542 **Dissection, deep jugular node(s)** **Global:** 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,058

2007 Work RVU: 6.08 **2009 Work RVU:** 7.85
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.3 **2009 Fac PE RVU:**4.49

RUC Recommendation: 7.85 **CPT Action? (if applicable):**

38571 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy** **Global:** 010 **Issue:** Laparoscopic Procedures **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 3,848

2007 Work RVU: 14.7 **2009 Work RVU:** 14.7
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.97 **2009 Fac PE RVU:**6.97

RUC Recommendation: Review SS plan at Oct 2009 Five-Year Review Identification Workgroup Meeting **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

42145 **Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)** **Global:** 090 **Issue:** Palatopharyngoplasty **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 41 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,226

2007 Work RVU: 9.63 **2009 Work RVU:** 9.63
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.33 **2009 Fac PE RVU:**7.55

RUC Recommendation: 9.63 **CPT Action? (if applicable):**

42415 **Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve** **Global:** 090 **Issue:** Parotid Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 23 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,504

2007 Work RVU: 17.99 **2009 Work RVU:** 17.99
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.11 **2009 Fac PE RVU:**9.50

RUC Recommendation: 17.99 **CPT Action? (if applicable):**

42420 **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve** **Global:** 090 **Issue:** Parotid Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 23 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,565

2007 Work RVU: 20.87 **2009 Work RVU:** 20.87
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.46 **2009 Fac PE RVU:**10.63

RUC Recommendation: 20.87 **CPT Action? (if applicable):**

42440 **Excision of submandibular (submaxillary) gland** **Global:** 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,291

2007 Work RVU: 7.05 **2009 Work RVU:** 7.05
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.48 **2009 Fac PE RVU:**4.42

RUC Recommendation: 7.05 **CPT Action? (if applicable):**

43236 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Gastrointestinal Endoscopy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** October 2008 **2007 Medicare Utilization Data:** 10,475

2007 Work RVU: 2.92 **2009 Work RVU:** 2.92
2007 NF PE RVU: 6.47 **2009 NF PE RVU:** 6.50
2007 Fac PE RVU:1.33 **2009 Fac PE RVU:**1.58

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):** CPT Assistant - April 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

43242 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)**

Global: 000 **Issue:** Gastrointestinal Endoscopy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** October 2008 **2007 Medicare Utilization Data:** 16,598

2007 Work RVU: 7.3 **2009 Work RVU:** 7.3
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.98 **2009 Fac PE RVU:**3.55

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):** CPT Assistant - March 2009

43259 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate**

Global: 000 **Issue:** Gastrointestinal Endoscopy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** October 2008 **2007 Medicare Utilization Data:** 24,100

2007 Work RVU: 5.19 **2009 Work RVU:** 5.19
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.17 **2009 Fac PE RVU:**2.60

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):** CPT Assistant - March 2009

44205 **Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 8,458

2007 Work RVU: 22.86 **2009 Work RVU:** 22.86
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:8.6 **2009 Fac PE RVU:**8.36

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

44207 **Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 4,939

2007 Work RVU: 31.79 **2009 Work RVU:** 31.79
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.17 **2009 Fac PE RVU:**10.87

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

44970 **Laparoscopy, surgical, appendectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 13,519

2007 Work RVU: 9.35 **2009 Work RVU:** 9.35
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.11 **2009 Fac PE RVU:**4.27

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

45170 **Excision of rectal tumor, transanal approach** **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,536

2007 Work RVU: 12.48 **2009 Work RVU:** 12.48
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.28 **2009 Fac PE RVU:**5.47

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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45171 **Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)** **Global:** **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 8.00 **CPT Action? (if applicable):**

45172 **Including muscularis propria (ie, full thickness) (For destruction of rectal tumor, transanal approach see 45190)** **Global:** **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 12.00 **CPT Action? (if applicable):**

45381 **Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** October 2008 **2007 Medicare Utilization Data:** 39,370

2007 Work RVU: 4.19 **2009 Work RVU:** 4.19
2007 NF PE RVU: 7.26 **2009 NF PE RVU:** 7.45
2007 Fac PE RVU:1.79 **2009 Fac PE RVU:**2.08

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):** CPT Assistant - March 2009

46200 **Fissurectomy, with or without sphincterotomy** **Global:** 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,806

2007 Work RVU: 3.48 **2009 Work RVU:** 3.48
2007 NF PE RVU: 4.46 **2009 NF PE RVU:** 5.63
2007 Fac PE RVU:3.08 **2009 Fac PE RVU:**3.51

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

47382 **Ablation, one or more liver tumor(s), percutaneous, radiofrequency** **Global:** 010 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2007 Medicare Utilization Data:** 1,520

2007 Work RVU: 15.19 **2009 Work RVU:** 15.19
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.83 **2009 Fac PE RVU:**6.64

RUC Recommendation: New PE Inputs **CPT Action? (if applicable):**

47490 **Percutaneous cholecystostomy** **Global:** 090 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 5,513

2007 Work RVU: 8.05 **2009 Work RVU:** 8.05
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.32 **2009 Fac PE RVU:**5.59

RUC Recommendation: Refer to CPT and recommend 000 day global **CPT Action? (if applicable):** June 2009

47525 **Change of percutaneous biliary drainage catheter** **Global:** 010 **Issue:** Change Biliary Drainage Catheter **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 14 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 10,611

2007 Work RVU: 5.55 **2009 Work RVU:** 1.54
2007 NF PE RVU: 14.8 **2009 NF PE RVU:** 11.98
2007 Fac PE RVU:2.67 **2009 Fac PE RVU:**1.35

RUC Recommendation: 1.54 **CPT Action? (if applicable):**

48102 **Biopsy of pancreas, percutaneous needle** **Global:** 000 **Issue:** Percutaneous Needle Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,293

2007 Work RVU: 4.68 **2009 Work RVU:** 4.68
2007 NF PE RVU: 8.21 **2009 NF PE RVU:** 9.28
2007 Fac PE RVU:1.85 **2009 Fac PE RVU:**2.06

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

49420 **Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary** **Global:** 000 **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 43 **Specialty Developing Recommendation:** ACS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 4,931

2007 Work RVU: 2.22 **2009 Work RVU:** 2.22
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:1.11 **2009 Fac PE RVU:**1.18

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

49421 **Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent** **Global:** 000 **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 43 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,908

2007 Work RVU: 5.87 **2009 Work RVU:** 5.87
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.15 **2009 Fac PE RVU:**3.20

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

49507 **Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 24 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 11,912

2007 Work RVU: 9.97 **2009 Work RVU:** 9.97
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.46 **2009 Fac PE RVU:**4.56

RUC Recommendation: 9.97 **CPT Action? (if applicable):**

49521 **Repair recurrent inguinal hernia, any age; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 24 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,961

2007 Work RVU: 12.36 **2009 Work RVU:** 12.36
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.18 **2009 Fac PE RVU:**5.19

RUC Recommendation: 12.36 **CPT Action? (if applicable):**

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 24 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 9,146

2007 Work RVU: 7.96 **2009 Work RVU:** 7.96
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.77 **2009 Fac PE RVU:**3.91

RUC Recommendation: 7.96 **CPT Action? (if applicable):**

50200 **Renal biopsy; percutaneous, by trocar or needle** **Global:** 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2007 Medicare Utilization Data:** 25,734

2007 Work RVU: 2.63 **2009 Work RVU:** 2.63
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:1.24 **2009 Fac PE RVU:**1.27

RUC Recommendation: New PE Inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

50542 **Laparoscopy, surgical; ablation of renal mass lesion(s)** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent October 2008 **Tab** 26 **Specialty Developing** AUA **First** October 2008 **2007 Medicare** 1,147
RUC Meeting: **Recommendation:** **Identified:** **Utilization Data:**

2007 Work RVU: 21.18 **2009 Work RVU:** 21.18
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:8.93 **2009 Fac PE RVU:**10.95

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

50548 **Laparoscopy, surgical; nephrectomy with total ureterectomy** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent October 2008 **Tab** 26 **Specialty Developing** AUA **First** October 2008 **2007 Medicare** 1,273
RUC Meeting: **Recommendation:** **Identified:** **Utilization Data:**

2007 Work RVU: 25.26 **2009 Work RVU:** 25.26
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.99 **2009 Fac PE RVU:**12.05

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

50605 **Ureterotomy for insertion of indwelling stent, all types** **Global:** 090 **Issue:** Ureterotomy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent October 2008 **Tab** 26 **Specialty Developing** AUA **First** October 2008 **2007 Medicare** 2,435
RUC Meeting: **Recommendation:** **Identified:** **Utilization Data:**

2007 Work RVU: 16.66 **2009 Work RVU:** 16.66
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.06 **2009 Fac PE RVU:**7.84

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** CPT Assistant - July 2009

51040 **Cystostomy, cystotomy with drainage** **Global:** 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent September 2007 **Tab** 16 **Specialty Developing** AUA **First** September 2007 **2007 Medicare** 5,942
RUC Meeting: **Recommendation:** **Identified:** **Utilization Data:**

2007 Work RVU: 4.43 **2009 Work RVU:** 4.43
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.01 **2009 Fac PE RVU:**3.55

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

51102 **Aspiration of bladder; with insertion of suprapubic catheter** **Global:** 010 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent April 2008 **Tab** 45 **Specialty Developing** AUA **First** September 2007 **2007 Medicare** 14,289
RUC Meeting: **Recommendation:** **Identified:** **Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 2.7
2007 NF PE RVU: 0 **2009 NF PE RVU:** 3.72
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.38

RUC Recommendation: 2.70 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

51726 **Complex cystometrogram (eg, calibrated electronic equipment)** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2008 **2007 Medicare Utilization Data:** 215,620

2007 Work RVU: 1.71 **2009 Work RVU:** 1.71
2007 NF PE RVU: 6.82 **2009 NF PE RVU:** 6.47
2007 Fac PE RVU:0.59 **2009 Fac PE RVU:**0.66

RUC Recommendation: 1.71 **CPT Action? (if applicable):** February 2009

51727 **Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 2.11 **CPT Action? (if applicable):**

51728 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 2.11 **CPT Action? (if applicable):**

51729 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), and urethral pressure profile studies (ie, urethral closure pressure profile), any technique** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 2.51 **CPT Action? (if applicable):**

51772 **Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 90,434

2007 Work RVU: 1.61 **2009 Work RVU:** 1.61
2007 NF PE RVU: 4.89 **2009 NF PE RVU:** 4.57
2007 Fac PE RVU:0.55 **2009 Fac PE RVU:**0.58

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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Status Report: CMS Requests and Five-Year Review ID WG Issues

51795 **Voiding pressure studies (VP); bladder voiding pressure, any technique** **Global:** 000 **Issue:** Urology Studies **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 170,390

2007 Work RVU: 1.53 **2009 Work RVU:** 1.53
2007 NF PE RVU: 6.63 **2009 NF PE RVU:** 6.19
2007 Fac PE RVU:0.52 **2009 Fac PE RVU:**0.58

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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51797 **Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 152,742

2007 Work RVU: 1.6 **2009 Work RVU:** 0.8
2007 NF PE RVU: 5 **2009 NF PE RVU:** 2.89
2007 Fac PE RVU:0.55 **2009 Fac PE RVU:**0.37

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Revised

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52214 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands** **Global:** 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 15 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2007 Medicare Utilization Data:** 27,914

2007 Work RVU: 3.7 **2009 Work RVU:** 3.7
2007 NF PE RVU: 33.55 **2009 NF PE RVU:** 12.58
2007 Fac PE RVU:1.47 **2009 Fac PE RVU:**2.36

RUC Recommendation: CPT Assistant; Review September 2011 **CPT Action? (if applicable):** CPT Assistant - Sept 2009

52224 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy** **Global:** 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 15 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 50,310

2007 Work RVU: 3.14 **2009 Work RVU:** 3.14
2007 NF PE RVU: 32.11 **2009 NF PE RVU:** 20.22
2007 Fac PE RVU:1.28 **2009 Fac PE RVU:**1.57

RUC Recommendation: CPT Assistant; Review September 2011 **CPT Action? (if applicable):** CPT Assistant - Sept 2009

52341 **Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2007 Medicare Utilization Data:** 1,953

2007 Work RVU: 6.11 **2009 Work RVU:** 5.35
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.44 **2009 Fac PE RVU:**2.75

RUC Recommendation: 5.35 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

52342 **Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2007 Medicare Utilization Data:** 314

2007 Work RVU: 6.61 **2009 Work RVU:** 5.85
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.59 **2009 Fac PE RVU:**2.96

RUC Recommendation: 5.85 **CPT Action? (if applicable):**

52343 **Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2007 Medicare Utilization Data:** 33

2007 Work RVU: 7.31 **2009 Work RVU:** 6.55
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.84 **2009 Fac PE RVU:**3.25

RUC Recommendation: 6.55 **CPT Action? (if applicable):**

52344 **Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,440

2007 Work RVU: 7.81 **2009 Work RVU:** 7.05
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.09 **2009 Fac PE RVU:**3.58

RUC Recommendation: 7.05 **CPT Action? (if applicable):**

52345 **Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2007 Medicare Utilization Data:** 473

2007 Work RVU: 8.31 **2009 Work RVU:** 7.55
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.27 **2009 Fac PE RVU:**3.79

RUC Recommendation: 7.55 **CPT Action? (if applicable):**

52346 **Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)** **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2007 Medicare Utilization Data:** 120

2007 Work RVU: 9.34 **2009 Work RVU:** 8.58
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.62 **2009 Fac PE RVU:**4.22

RUC Recommendation: 8.58 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

52400 **Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 710

2007 Work RVU: 10.06 **2009 Work RVU:** 8.66
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.18 **2009 Fac PE RVU:**4.69

RUC Recommendation: 8.66 **CPT Action? (if applicable):**

52500 **Transurethral resection of bladder neck (separate procedure)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,821

2007 Work RVU: 9.39 **2009 Work RVU:** 7.99
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.52 **2009 Fac PE RVU:**5.38

RUC Recommendation: 7.99 **CPT Action? (if applicable):**

52640 **Transurethral resection; of postoperative bladder neck contracture** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,467

2007 Work RVU: 6.89 **2009 Work RVU:** 4.73
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.35 **2009 Fac PE RVU:**3.51

RUC Recommendation: 4.73 **CPT Action? (if applicable):**

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)** **Global:** 090 **Issue:** Laser Surgery of Prostate **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 35,369

2007 Work RVU: 12 **2009 Work RVU:** 12
2007 NF PE RVU: 66.1 **2009 NF PE RVU:** 50.13
2007 Fac PE RVU:5.44 **2009 Fac PE RVU:**6.90

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

53445 **Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,834

2007 Work RVU: 15.21 **2009 Work RVU:** 15.21
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.55 **2009 Fac PE RVU:**9.01

RUC Recommendation: 15.21 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

54405 **Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,362

2007 Work RVU: 14.39 **2009 Work RVU:** 14.39
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.51 **2009 Fac PE RVU:**7.93

RUC Recommendation: 14.39 **CPT Action? (if applicable):**

54410 **Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,294

2007 Work RVU: 16.48 **2009 Work RVU:** 15
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.35 **2009 Fac PE RVU:**8.72

RUC Recommendation: 15.00 **CPT Action? (if applicable):**

54520 **Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach** **Global:** 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,287

2007 Work RVU: 5.25 **2009 Work RVU:** 5.25
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.03 **2009 Fac PE RVU:**3.59

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

54530 **Orchiectomy, radical, for tumor; inguinal approach** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,436

2007 Work RVU: 9.31 **2009 Work RVU:** 8.35
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.72 **2009 Fac PE RVU:**5.52

RUC Recommendation: 8.35 **CPT Action? (if applicable):**

55866 **Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing** **Global:** 090 **Issue:** Lap Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 9,800

2007 Work RVU: 32.25 **2009 Work RVU:** 32.25
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:12.87 **2009 Fac PE RVU:**15.76

RUC Recommendation: Review October 2009 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

55873 **Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)** **Global:** 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 25 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,647

2007 Work RVU: 20.25 **2009 Work RVU:** 20.25
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.59 **2009 Fac PE RVU:**11.20

RUC Recommendation: 13.45 **CPT Action? (if applicable):**

56515 **Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)** **Global:** 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,758

2007 Work RVU: 3.03 **2009 Work RVU:** 3.03
2007 NF PE RVU: 2.5 **2009 NF PE RVU:** 2.46
2007 Fac PE RVU:1.79 **2009 Fac PE RVU:**1.80

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

56620 **Vulvectomy simple; partial** **Global:** 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** D **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,186

2007 Work RVU: 8.44 **2009 Work RVU:** 7.35
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.7 **2009 Fac PE RVU:**4.74

RUC Recommendation: 7.35 **CPT Action? (if applicable):**

57155 **Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy** **Global:** 090 **Issue:** Insertion of Uteri Tandems **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,430

2007 Work RVU: 6.79 **2009 Work RVU:** 6.79
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.3 **2009 Fac PE RVU:**3.84

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

57287 **Removal or revision of sling for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,668

2007 Work RVU: 11.49 **2009 Work RVU:** 10.97
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.73 **2009 Fac PE RVU:**6.66

RUC Recommendation: 10.97 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

57288 **Sling operation for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** O **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 44,894

2007 Work RVU: 14.01 **2009 Work RVU:** 12
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.21 **2009 Fac PE RVU:**6.41

RUC Recommendation: 12.00 **CPT Action? (if applicable):**

58555 **Hysteroscopy, diagnostic (separate procedure)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2007 Medicare Utilization Data:** 1,892

2007 Work RVU: 3.33 **2009 Work RVU:** 3.33
2007 NF PE RVU: 2.32 **2009 NF PE RVU:** 2.63
2007 Fac PE RVU:1.47 **2009 Fac PE RVU:**1.35

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

58558 **Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2007 Medicare Utilization Data:** 36,047

2007 Work RVU: 4.74 **2009 Work RVU:** 4.74
2007 NF PE RVU: 2.52 **2009 NF PE RVU:** 3.29
2007 Fac PE RVU:2.05 **2009 Fac PE RVU:**1.85

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

58562 **Hysteroscopy, surgical; with removal of impacted foreign body** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2007 Medicare Utilization Data:** 70

2007 Work RVU: 5.2 **2009 Work RVU:** 5.2
2007 NF PE RVU: 2.63 **2009 NF PE RVU:** 3.27
2007 Fac PE RVU:2.21 **2009 Fac PE RVU:**1.98

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

58563 **Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2007 Medicare Utilization Data:** 4,851

2007 Work RVU: 6.16 **2009 Work RVU:** 6.16
2007 NF PE RVU: 51.38 **2009 NF PE RVU:** 41.54
2007 Fac PE RVU:2.58 **2009 Fac PE RVU:**2.31

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

58660 **Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)** **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,979

2007 Work RVU: 11.54 **2009 Work RVU:** 11.54
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.07 **2009 Fac PE RVU:**4.84

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

58661 **Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)** **Global:** 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2007 Medicare Utilization Data:** 8,094

2007 Work RVU: 11.3 **2009 Work RVU:** 11.3
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.84 **2009 Fac PE RVU:**4.44

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

59400 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,714

2007 Work RVU: 26.8 **2009 Work RVU:** 26.8
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:15.06 **2009 Fac PE RVU:**14.71

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59409 **Vaginal delivery only (with or without episiotomy and/or forceps);** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,441

2007 Work RVU: 13.48 **2009 Work RVU:** 13.48
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.91 **2009 Fac PE RVU:**4.29

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59410 **Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,180

2007 Work RVU: 15.29 **2009 Work RVU:** 15.29
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.96 **2009 Fac PE RVU:**5.49

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

59412 **External cephalic version, with or without tocolysis** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 25

2007 Work RVU: 1.71 **2009 Work RVU:** 1.71
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.77 **2009 Fac PE RVU:**0.70

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59414 **Delivery of placenta (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 33

2007 Work RVU: 1.61 **2009 Work RVU:** 1.61
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.59 **2009 Fac PE RVU:**0.51

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59425 **Antepartum care only; 4-6 visits** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 743

2007 Work RVU: 6.22 **2009 Work RVU:** 6.22
2007 NF PE RVU: 4.21 **2009 NF PE RVU:** 4.29
2007 Fac PE RVU:1.81 **2009 Fac PE RVU:**1.82

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59426 **Antepartum care only; 7 or more visits** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 775

2007 Work RVU: 11.04 **2009 Work RVU:** 11.04
2007 NF PE RVU: 7.6 **2009 NF PE RVU:** 7.81
2007 Fac PE RVU:3.17 **2009 Fac PE RVU:**3.21

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59430 **Postpartum care only (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 1,206

2007 Work RVU: 2.13 **2009 Work RVU:** 2.13
2007 NF PE RVU: 1.19 **2009 NF PE RVU:** 1.14
2007 Fac PE RVU:0.88 **2009 Fac PE RVU:**0.79

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

59510 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 2,923

2007 Work RVU: 30.34 **2009 Work RVU:** 30.34
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:16.92 **2009 Fac PE RVU:**16.65

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59515 **Cesarean delivery only; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 1,049

2007 Work RVU: 18.26 **2009 Work RVU:** 18.26
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.43 **2009 Fac PE RVU:**6.84

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59610 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 55

2007 Work RVU: 28.21 **2009 Work RVU:** 28.21
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:15.52 **2009 Fac PE RVU:**15.45

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59612 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 44

2007 Work RVU: 15.04 **2009 Work RVU:** 15.04
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.6 **2009 Fac PE RVU:**4.88

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59614 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 31

2007 Work RVU: 16.59 **2009 Work RVU:** 16.59
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.49 **2009 Fac PE RVU:**5.82

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

59618 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 14

2007 Work RVU: 31.78 **2009 Work RVU:** 31.78
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:17.74 **2009 Fac PE RVU:**17.33

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59620 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 6

2007 Work RVU: 17.5 **2009 Work RVU:** 17.5
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:6.27 **2009 Fac PE RVU:**5.61

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

59622 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 27 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2007 Medicare Utilization Data:** 5

2007 Work RVU: 19.7 **2009 Work RVU:** 19.7
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:8.14 **2009 Fac PE RVU:**7.50

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

60220 **Total thyroid lobectomy, unilateral; with or without isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 8,878

2007 Work RVU: 12.29 **2009 Work RVU:** 12.29
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.96 **2009 Fac PE RVU:**5.97

RUC Recommendation: 12.29 **CPT Action? (if applicable):**

60225 **Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,021

2007 Work RVU: 14.67 **2009 Work RVU:** 14.67
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.22 **2009 Fac PE RVU:**7.24

RUC Recommendation: 14.67 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

61793 **Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 12,298

2007 Work RVU: 17.75 **2009 Work RVU:**
2007 NF PE RVU: NA **2009 NF PE RVU:**
2007 Fac PE RVU: 10.08 **2009 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2008 - Deleted from CPT

61795 **Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 18,122

2007 Work RVU: 4.03 **2009 Work RVU:** 4.03
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU: 1.87 **2009 Fac PE RVU:** 1.65

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

61796 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 10.79
2007 NF PE RVU: 0 **2009 NF PE RVU:** NA
2007 Fac PE RVU: 0 **2009 Fac PE RVU:** 6.85

RUC Recommendation: 15.50 **CPT Action? (if applicable):**

61797 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 3.48
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.34
2007 Fac PE RVU: 0 **2009 Fac PE RVU:** 1.34

RUC Recommendation: 3.48 **CPT Action? (if applicable):**

61798 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 10.79
2007 NF PE RVU: 0 **2009 NF PE RVU:** NA
2007 Fac PE RVU: 0 **2009 Fac PE RVU:** 6.85

RUC Recommendation: 19.75 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

61799 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 4.81
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.85
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.85

RUC Recommendation: 4.81 **CPT Action? (if applicable):**

61800 **Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 16 **Specialty Developing Recommendation:** **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 2.25
2007 NF PE RVU: 0 **2009 NF PE RVU:** NA
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.11

RUC Recommendation: 2.25 **CPT Action? (if applicable):**

61885 **Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array**

Global: 090 **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,278

2007 Work RVU: 7.37 **2009 Work RVU:** 7.37
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.85 **2009 Fac PE RVU:**6.87

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

62263 **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days**

Global: 010 **Issue:** Epidual Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** G **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,562

2007 Work RVU: 6.41 **2009 Work RVU:** 6.41
2007 NF PE RVU: 11.78 **2009 NF PE RVU:** 9.74
2007 Fac PE RVU:3.11 **2009 Fac PE RVU:**2.96

RUC Recommendation: 6.41 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

62281 **Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic**

Global: 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,010

2007 Work RVU: 2.66 **2009 Work RVU:** 2.66
2007 NF PE RVU: 5.16 **2009 NF PE RVU:** 4.41
2007 Fac PE RVU:0.89 **2009 Fac PE RVU:**1.00

RUC Recommendation: Remove 99238 **CPT Action? (if applicable):**

62287 **Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy)**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,944

2007 Work RVU: 8.88 **2009 Work RVU:** 8.88
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.18 **2009 Fac PE RVU:**4.70

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

62350 **Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**

Global: 090 **Issue:** Intrathecal/Epidural Catheters/Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** H **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,572

2007 Work RVU: 8.04 **2009 Work RVU:** 6
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4 **2009 Fac PE RVU:**3.09

RUC Recommendation: 6.00 **CPT Action? (if applicable):**

62355 **Removal of previously implanted intrathecal or epidural catheter**

Global: 090 **Issue:** Intrathecal/Epidural Catheters/Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** H **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,439

2007 Work RVU: 6.6 **2009 Work RVU:** 4.3
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.27 **2009 Fac PE RVU:**2.56

RUC Recommendation: 4.30 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

62360 **Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir** **Global:** 090 **Issue:** Intrathecal/Epidural Catheters/Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 48 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 603

2007 Work RVU: 3.68 **2009 Work RVU:** 4.28
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:2.87 **2009 Fac PE RVU:**2.55

RUC Recommendation: 4.28 **CPT Action? (if applicable):**

62361 **Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump** **Global:** 090 **Issue:** Intrathecal/Epidural Catheters/Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** H **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 375

2007 Work RVU: 6.59 **2009 Work RVU:** 5.6
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.94 **2009 Fac PE RVU:**3.60

RUC Recommendation: 5.60 **CPT Action? (if applicable):**

62362 **Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming** **Global:** 090 **Issue:** Intrathecal/Epidural Catheters/Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** H **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 6,719

2007 Work RVU: 8.58 **2009 Work RVU:** 6.05
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.46 **2009 Fac PE RVU:**3.43

RUC Recommendation: 6.05 **CPT Action? (if applicable):**

62365 **Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion** **Global:** 090 **Issue:** Intrathecal/Epidural Catheters/Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 48 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,431

2007 Work RVU: 6.57 **2009 Work RVU:** 4.6
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.65 **2009 Fac PE RVU:**2.94

RUC Recommendation: 4.60 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

63056 **Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)**

Global: 090 **Issue:** Decompression of Spinal Cord **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 5,817

2007 Work RVU: 21.73 **2009 Work RVU:** 21.73
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:12.31 **2009 Fac PE RVU:**11.94

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Global: 090 **Issue:** Discectomy **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 23,998

2007 Work RVU: 19.47 **2009 Work RVU:** 19.47
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.87 **2009 Fac PE RVU:**11.51

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

63620 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion**

Global: 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 10.79
2007 NF PE RVU: 0 **2009 NF PE RVU:** NA
2007 Fac PE RVU:0 **2009 Fac PE RVU:**6.85

RUC Recommendation: 15.50 **CPT Action? (if applicable):**

63621 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 4
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.54
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.54

RUC Recommendation: 4.00 **CPT Action? (if applicable):**

63650 **Percutaneous implantation of neurostimulator electrode array, epidural**

Global: 090 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 24,967

2007 Work RVU: 7.57 **2009 Work RVU:** 7.15
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.11 **2009 Fac PE RVU:**2.83

RUC Recommendation: 7.15 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

63655 **Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural** **Global:** 090 **Issue:** Neurostimulator (Spinal) **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,613

2007 Work RVU: 11.43 **2009 Work RVU:** 11.43
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.15 **2009 Fac PE RVU:**7.58

RUC Recommendation: 11.43 **CPT Action? (if applicable):**

63660 **Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)** **Global:** 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,784

2007 Work RVU: 6.87 **2009 Work RVU:** 6.87
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.54 **2009 Fac PE RVU:**3.52

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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63661 **Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed** **Global:** 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 5.02 **CPT Action? (if applicable):**

63662 **Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed** **Global:** 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 10.84 **CPT Action? (if applicable):**

63663 **Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed** **Global:** 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 7.68 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

63664 **Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 11.34 **CPT Action? (if applicable):**

63685 **Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 090 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 7,699

2007 Work RVU: 7.87 **2009 Work RVU:** 6
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.03 **2009 Fac PE RVU:**3.22

RUC Recommendation: 6.00 **CPT Action? (if applicable):**

63688 **Revision or removal of implanted spinal neurostimulator pulse generator or receiver**

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

Most Recent RUC Meeting: February 2008 **Tab** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,410

2007 Work RVU: 6.1 **2009 Work RVU:** 5.25
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.56 **2009 Fac PE RVU:**3.05

RUC Recommendation: 5.25 **CPT Action? (if applicable):**

64415 **Injection, anesthetic agent; brachial plexus, single**

Global: 000 **Issue:** Injection of Anesthetic Agent - Nerve **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 76,092

2007 Work RVU: 1.48 **2009 Work RVU:** 1.48
2007 NF PE RVU: 2.47 **2009 NF PE RVU:** 1.75
2007 Fac PE RVU:0.43 **2009 Fac PE RVU:**0.35

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

64416 **Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration**

Global: 010 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 5,005

2007 Work RVU: 3.85 **2009 Work RVU:** 1.81
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.74 **2009 Fac PE RVU:**0.36

RUC Recommendation: 1.81 **CPT Action? (if applicable):** February 2008

64445 **Injection, anesthetic agent; sciatic nerve, single**

Global: 000 **Issue:** Injection of Anesthetic Agent - Nerve **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 65,529

2007 Work RVU: 1.48 **2009 Work RVU:** 1.48
2007 NF PE RVU: 2.42 **2009 NF PE RVU:** 1.87
2007 Fac PE RVU:0.51 **2009 Fac PE RVU:**0.51

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

64446 **Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement), including daily management for anesthetic agent administration**

Global: 010 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 4,399

2007 Work RVU: 3.61 **2009 Work RVU:** 1.81
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.9 **2009 Fac PE RVU:**0.43

RUC Recommendation: 1.81 **CPT Action? (if applicable):** February 2008

64447 **Injection, anesthetic agent; femoral nerve, single**

Global: 000 **Issue:** Injection of Anesthetic Agent - Nerve **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 77,645

2007 Work RVU: 1.5 **2009 Work RVU:** 1.5
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.38 **2009 Fac PE RVU:**0.24

RUC Recommendation: Defer to October 2009 **CPT Action? (if applicable):**

64448 **Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration**

Global: 010 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 40,717

2007 Work RVU: 3.36 **2009 Work RVU:** 1.63
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.73 **2009 Fac PE RVU:**0.35

RUC Recommendation: 1.63 **CPT Action? (if applicable):** February 2008

Status Report: CMS Requests and Five-Year Review ID WG Issues

64449 **Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration** **Global:** 010 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,774

2007 Work RVU: 3.24 **2009 Work RVU:** 1.81
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.84 **2009 Fac PE RVU:**0.44

RUC Recommendation: 1.81 **CPT Action? (if applicable):** February 2008

64470 **Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2007 Medicare Utilization Data:** 133,092

2007 Work RVU: 1.85 **2009 Work RVU:** 1.85
2007 NF PE RVU: 6.37 **2009 NF PE RVU:** 4.68
2007 Fac PE RVU:0.71 **2009 Fac PE RVU:**0.73

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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64472 **Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2007 Medicare Utilization Data:** 215,038

2007 Work RVU: 1.29 **2009 Work RVU:** 1.29
2007 NF PE RVU: 2.05 **2009 NF PE RVU:** 1.51
2007 Fac PE RVU:0.34 **2009 Fac PE RVU:**0.35

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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64475 **Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2007 Medicare Utilization Data:** 485,428

2007 Work RVU: 1.41 **2009 Work RVU:** 1.41
2007 NF PE RVU: 6.07 **2009 NF PE RVU:** 4.44
2007 Fac PE RVU:0.62 **2009 Fac PE RVU:**0.61

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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64476 **Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2007 Medicare Utilization Data:** 742,516

2007 Work RVU: 0.98 **2009 Work RVU:** 0.98
2007 NF PE RVU: 1.86 **2009 NF PE RVU:** 1.37
2007 Fac PE RVU:0.24 **2009 Fac PE RVU:**0.24

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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Status Report: CMS Requests and Five-Year Review ID WG Issues

64483 **Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level** **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 578,896

2007 Work RVU: 1.9 **2009 Work RVU:** 1.9
2007 NF PE RVU: 6.86 **2009 NF PE RVU:** 4.83
2007 Fac PE RVU:0.81 **2009 Fac PE RVU:**0.79

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

64484 **Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 296,104

2007 Work RVU: 1.33 **2009 Work RVU:** 1.33
2007 NF PE RVU: 2.86 **2009 NF PE RVU:** 2.06
2007 Fac PE RVU:0.36 **2009 Fac PE RVU:**0.36

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

64490 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level** **Global:** 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.82 **CPT Action? (if applicable):**

64491 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level** **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.16 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

64492 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)** **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.16 **CPT Action? (if applicable):**

64493 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level** **Global:** 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.52 **CPT Action? (if applicable):**

64494 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level** **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.00 **CPT Action? (if applicable):**

64495 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)** **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.00 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

64510 **Injection, anesthetic agent; stellate ganglion (cervical sympathetic)** **Global:** 000 **Issue:** Fluroscopy **Screen:** CMS Request - Review PE **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2007 Medicare Utilization Data:** 8,450

2007 Work RVU: 1.22 **2009 Work RVU:** 1.22
2007 NF PE RVU: 3.06 **2009 NF PE RVU:** 2.30
2007 Fac PE RVU:0.49 **2009 Fac PE RVU:**0.46

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

64520 **Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)** **Global:** 000 **Issue:** Fluroscopy **Screen:** CMS Request - Review PE **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2007 Medicare Utilization Data:** 18,201

2007 Work RVU: 1.35 **2009 Work RVU:** 1.35
2007 NF PE RVU: 4.5 **2009 NF PE RVU:** 3.27
2007 Fac PE RVU:0.54 **2009 Fac PE RVU:**0.55

RUC Recommendation: PE Review - no change **CPT Action? (if applicable):**

64555 **Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)** **Global:** 010 **Issue:** Neurostimulators **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACOG **First Identified:** February 2008 **2007 Medicare Utilization Data:** 31,723

2007 Work RVU: 2.29 **2009 Work RVU:** 2.29
2007 NF PE RVU: 2.96 **2009 NF PE RVU:** 3.01
2007 Fac PE RVU:1.23 **2009 Fac PE RVU:**1.53

RUC Recommendation: Refer to CPT, Re-review September 2011 **CPT Action? (if applicable):** CPT Assistant - Sept 2009

64561 **Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)** **Global:** 010 **Issue:** Neurostimulators **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ISIS, AUA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 3,727

2007 Work RVU: 7.07 **2009 Work RVU:** 7.07
2007 NF PE RVU: 27.51 **2009 NF PE RVU:** 22.04
2007 Fac PE RVU:3.05 **2009 Fac PE RVU:**3.64

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

64573 **Incision for implantation of neurostimulator electrodes; cranial nerve** **Global:** 090 **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 952

2007 Work RVU: 8.15 **2009 Work RVU:** 8.15
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.31 **2009 Fac PE RVU:**5.31

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

64581 **Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,423

2007 Work RVU: 14.15 **2009 Work RVU:** 14.15
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:5.73 **2009 Fac PE RVU:**6.59

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

64622 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level** **Global:** 010 **Issue:** Fluroscopy **Screen:** CMS Request - Review PE, High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2007 Medicare Utilization Data:** 104,081

2007 Work RVU: 3.02 **2009 Work RVU:** 3.02
2007 NF PE RVU: 6.82 **2009 NF PE RVU:** 5.02
2007 Fac PE RVU:1.34 **2009 Fac PE RVU:**1.33

RUC Recommendation: PE Review - no change **CPT Action? (if applicable):** June 2008

64623 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2007 Medicare Utilization Data:** 235,618

2007 Work RVU: 0.99 **2009 Work RVU:** 0.99
2007 NF PE RVU: 2.62 **2009 NF PE RVU:** 2.00
2007 Fac PE RVU:0.22 **2009 Fac PE RVU:**0.23

RUC Recommendation: 0.99 **CPT Action? (if applicable):** June 2008

64626 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level** **Global:** 010 **Issue:** Fluroscopy **Screen:** CMS Request - Review PE, High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2007 Medicare Utilization Data:** 20,603

2007 Work RVU: 3.82 **2009 Work RVU:** 3.82
2007 NF PE RVU: 6.99 **2009 NF PE RVU:** 5.54
2007 Fac PE RVU:1.93 **2009 Fac PE RVU:**1.95

RUC Recommendation: PE Reivew - no change **CPT Action? (if applicable):** June 2008

64627 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2007 Medicare Utilization Data:** 41,772

2007 Work RVU: 1.16 **2009 Work RVU:** 1.16
2007 NF PE RVU: 3.98 **2009 NF PE RVU:** 2.93
2007 Fac PE RVU:0.26 **2009 Fac PE RVU:**0.27

RUC Recommendation: 1.16 **CPT Action? (if applicable):** June 2008

Status Report: CMS Requests and Five-Year Review ID WG Issues

64640 **Destruction by neurolytic agent; other peripheral nerve or branch** **Global:** 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** APMA **First Identified:** September 2007 **2007 Medicare Utilization Data:** 93,903

2007 Work RVU: 2.78 **2009 Work RVU:** 2.78
2007 NF PE RVU: 3.75 **2009 NF PE RVU:** 2.83
2007 Fac PE RVU:1.75 **2009 Fac PE RVU:**1.52

RUC Recommendation: Remove 99238 **CPT Action? (if applicable):**

64708 **Neuroplasty, major peripheral nerve, arm or leg; other than specified** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 49 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,193

2007 Work RVU: 6.22 **2009 Work RVU:** 6.22
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.73 **2009 Fac PE RVU:**5.00

RUC Recommendation: 6.22 **CPT Action? (if applicable):**

64712 **Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 49 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,260

2007 Work RVU: 7.98 **2009 Work RVU:** 7.98
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:4.86 **2009 Fac PE RVU:**5.01

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

64831 **Suture of digital nerve, hand or foot; one nerve** **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** K **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,127

2007 Work RVU: 10.23 **2009 Work RVU:** 9
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7 **2009 Fac PE RVU:**6.86

RUC Recommendation: 9.00 **CPT Action? (if applicable):**

65105 **Enucleation of eye; with implant, muscles attached to implant** **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 978

2007 Work RVU: 9.7 **2009 Work RVU:** 9.7
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.13 **2009 Fac PE RVU:**9.41

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

65285 **Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue**

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

Most Recent RUC Meeting: February 2008 **Tab** L **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,167

2007 Work RVU: 14.43 **2009 Work RVU:** 14.43
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.12 **2009 Fac PE RVU:**8.96

RUC Recommendation: 14.43 **CPT Action? (if applicable):**

65780 **Ocular surface reconstruction; amniotic membrane transplantation**

Global: 090 **Issue:** Ophthalmological Procedures **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAO, ASCRS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,651

2007 Work RVU: 10.43 **2009 Work RVU:** 10.43
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:10.04 **2009 Fac PE RVU:**9.49

RUC Recommendation: CPT Assistant Article **CPT Action? (if applicable):** CPT Assistant - June 2009

66761 **Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions)**

Global: 090 **Issue:** Iridotomy and Iridectomy **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 57 **Specialty Developing Recommendation:** ASCRS, AAO **First Identified:** February 2008 **2007 Medicare Utilization Data:** 85,496

2007 Work RVU: 4.87 **2009 Work RVU:** 4.87
2007 NF PE RVU: 5.49 **2009 NF PE RVU:** 5.26
2007 Fac PE RVU:4.32 **2009 Fac PE RVU:**4.33

RUC Recommendation: Change global to 010-day or refer to CPT. **CPT Action? (if applicable):**

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

Global: 090 **Issue:** Cataract Surgery **Screen:** High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAO, ASCRS (cataract), AOA (optometric) **First Identified:** September 2007 **2007 Medicare Utilization Data:** 108,581

2007 Work RVU: 14.83 **2009 Work RVU:** 14.83
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.75 **2009 Fac PE RVU:**9.26

RUC Recommendation: CPT Assistant; Reduce to 2x99213 & 3x99212; Re-review September 2011 **CPT Action? (if applicable):** CPT Assistant - Sept 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

66984 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)** **Global:** 090 **Issue:** Cataract Surgery **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAO, ASCRS (cataract), AOA (optometric) **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,712,344

2007 Work RVU: 10.36 **2009 Work RVU:** 10.36
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.24 **2009 Fac PE RVU:**6.96

RUC Recommendation: Remove from screen. Review again in September 2011 **CPT Action? (if applicable):**

67028 **Intravitreal injection of a pharmacologic agent (separate procedure)** **Global:** 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2007 Medicare Utilization Data:** 816,559

2007 Work RVU: 2.52 **2009 Work RVU:** 2.52
2007 NF PE RVU: 2.59 **2009 NF PE RVU:** 2.35
2007 Fac PE RVU:1.42 **2009 Fac PE RVU:**1.36

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

67038 **Vitrectomy, mechangical, pars plana approach; with epiretinal membrane stripping** **Global:** **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 56,298

2007 Work RVU: 23.3 **2009 Work RVU:**
2007 NF PE RVU: NA **2009 NF PE RVU:**
2007 Fac PE RVU:15.16 **2009 Fac PE RVU:**

RUC Recommendation: Remove from screen **CPT Action? (if applicable):** February 2007 - Deleted from CPT

67039 **Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation** **Global:** 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 4,521

2007 Work RVU: 16.39 **2009 Work RVU:** 16.39
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.94 **2009 Fac PE RVU:**11.48

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

67040 **Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 19,174

2007 Work RVU: 19.23 **2009 Work RVU:** 19.23
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:13.41 **2009 Fac PE RVU:**12.90

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

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**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 2,657

2007 Work RVU: 16.35 **2009 Work RVU:** 16.35
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:11.19 **2009 Fac PE RVU:**10.99

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

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**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 19,993

2007 Work RVU: 22.49 **2009 Work RVU:** 22.49
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:14.22 **2009 Fac PE RVU:**13.87

RUC Recommendation: Reduce 99238 to 0.5 **CPT Action? (if applicable):**

67110 **Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)**

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

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 3,484

2007 Work RVU: 10.02 **2009 Work RVU:** 10.02
2007 NF PE RVU: 9.99 **2009 NF PE RVU:** 9.48
2007 Fac PE RVU:7.37 **2009 Fac PE RVU:**7.31

RUC Recommendation: Remove 99238 **CPT Action? (if applicable):**

67210 **Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2007 Medicare Utilization Data:** 140,062

2007 Work RVU: 9.35 **2009 Work RVU:** 9.35
2007 NF PE RVU: 6.48 **2009 NF PE RVU:** 6.31
2007 Fac PE RVU:5.84 **2009 Fac PE RVU:**5.78

RUC Recommendation: Review SS plan at Oct 2009 Five-Year Review Identification Workgroup Meeting. **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

67220 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2007 Medicare Utilization Data:** 13,843

2007 Work RVU: 14.19 **2009 Work RVU:** 14.19
2007 NF PE RVU: 10.23 **2009 NF PE RVU:** 9.87
2007 Fac PE RVU:8.9 **2009 Fac PE RVU:**8.73

RUC Recommendation: Review SS plan at Oct 2009 Five-Year Review Identification Workgroup Meeting. **CPT Action? (if applicable):**

67225 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)**

Global: ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,342

2007 Work RVU: 0.47 **2009 Work RVU:** 0.47
2007 NF PE RVU: 0.25 **2009 NF PE RVU:** 0.23
2007 Fac PE RVU:0.2 **2009 Fac PE RVU:**0.19

RUC Recommendation: 0.47 **CPT Action? (if applicable):**

67228 **Treatment of extensive or progressive retinopathy, one or more sessions; (eg, diabetic retinopathy), photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2007 Medicare Utilization Data:** 93,654

2007 Work RVU: 13.67 **2009 Work RVU:** 13.67
2007 NF PE RVU: 11.2 **2009 NF PE RVU:** 13.35
2007 Fac PE RVU:8.43 **2009 Fac PE RVU:**10.10

RUC Recommendation: Review SS plan at Oct 2009 Five-Year Review Identification Workgroup Meeting. **CPT Action? (if applicable):**

68040 **Expression of conjunctival follicles (eg, for trachoma)**

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 4,681

2007 Work RVU: 0.85 **2009 Work RVU:** 0.85
2007 NF PE RVU: 0.69 **2009 NF PE RVU:** 0.65
2007 Fac PE RVU:0.42 **2009 Fac PE RVU:**0.39

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

68810 **Probing of nasolacrimal duct, with or without irrigation;**

Global: 010 **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** L **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 33,064

2007 Work RVU: 2.63 **2009 Work RVU:** 2.09
2007 NF PE RVU: 3.62 **2009 NF PE RVU:** 3.29
2007 Fac PE RVU:2.7 **2009 Fac PE RVU:**2.20

RUC Recommendation: 2.09 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

69100 **Biopsy external ear** — **Global:** 000 — **Issue:** Biopsy of Ear — **Screen:** CMS Fastest Growing — **Complete?** Yes

Most Recent RUC Meeting: April 2009 — **Tab** 28 — **Specialty Developing Recommendation:** AAD — **First Identified:** October 2008 — **2007 Medicare Utilization Data:** 82,587

2007 Work RVU: 0.81 — **2009 Work RVU:** 0.81
2007 NF PE RVU: 1.75 — **2009 NF PE RVU:** 1.80
2007 Fac PE RVU:0.4 — **2009 Fac PE RVU:**0.41

RUC Recommendation: 0.81 — **CPT Action? (if applicable):**

69801 **Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal** — **Global:** 090 — **Issue:** Labyrinthotomy — **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) — **Complete?** No

Most Recent RUC Meeting: February 2009 — **Tab** 38 — **Specialty Developing Recommendation:** AAO-HNS — **First Identified:** September 2007 — **2007 Medicare Utilization Data:** 4,271

2007 Work RVU: 8.61 — **2009 Work RVU:** 8.61
2007 NF PE RVU: NA — **2009 NF PE RVU:** NA
2007 Fac PE RVU:9.31 — **2009 Fac PE RVU:**9.62

RUC Recommendation: The RUC recommends that this service be surveyed — **CPT Action? (if applicable):**

69930 **Cochlear device implantation, with or without mastoidectomy** — **Global:** 090 — **Issue:** Cochlear Device Implantation — **Screen:** Site of Service Anomaly — **Complete?** Yes

Most Recent RUC Meeting: February 2008 — **Tab** M — **Specialty Developing Recommendation:** AAO-HNS — **First Identified:** September 2007 — **2007 Medicare Utilization Data:** 1,608

2007 Work RVU: 17.6 — **2009 Work RVU:** 17.6
2007 NF PE RVU: NA — **2009 NF PE RVU:** NA
2007 Fac PE RVU:14.06 — **2009 Fac PE RVU:**12.90

RUC Recommendation: 17.60 — **CPT Action? (if applicable):**

70496 **Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing** — **Global:** XXX — **Issue:** CT Angiography — **Screen:** High Volume Growth / CMS Fastest Growing — **Complete?** No

Most Recent RUC Meeting: April 2008 — **Tab** 57 — **Specialty Developing Recommendation:** ACR, ASNR — **First Identified:** February 2008 — **2007 Medicare Utilization Data:** 86,896

2007 Work RVU: 1.75 — **2009 Work RVU:** 1.75
2007 NF PE RVU: 11.87 — **2009 NF PE RVU:** 14.83
2007 Fac PE RVU:0.56 — **2009 Fac PE RVU:**0.66

RUC Recommendation: Review September 2011 — **CPT Action? (if applicable):**

70498 **Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing** — **Global:** XXX — **Issue:** CT Angiography — **Screen:** High Volume Growth / CMS Fastest Growing — **Complete?** No

Most Recent RUC Meeting: April 2008 — **Tab** 57 — **Specialty Developing Recommendation:** ACR, ASNR — **First Identified:** February 2008 — **2007 Medicare Utilization Data:** 122,620

2007 Work RVU: 1.75 — **2009 Work RVU:** 1.75
2007 NF PE RVU: 11.89 — **2009 NF PE RVU:** 14.9
2007 Fac PE RVU:0.56 — **2009 Fac PE RVU:**0.67

RUC Recommendation: Review September 2011 — **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

71250 **Computed tomography, thorax; without contrast material** **Global:** XXX **Issue:** CT Thorax **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,352,505

2007 Work RVU: 1.16 **2009 Work RVU:** 1.16
2007 NF PE RVU: 5.87 **2009 NF PE RVU:** 5.95
2007 Fac PE RVU:0.37 **2009 Fac PE RVU:**0.43

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

71275 **Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Global:** XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 508,068

2007 Work RVU: 1.92 **2009 Work RVU:** 1.92
2007 NF PE RVU: 11.92 **2009 NF PE RVU:** 11.27
2007 Fac PE RVU:0.61 **2009 Fac PE RVU:**0.72

RUC Recommendation: CPT Assistant; Review September 2011 **CPT Action? (if applicable):** CPT Assistant - June 2009

72125 **Computed tomography, cervical spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 432,179

2007 Work RVU: 1.16 **2009 Work RVU:** 1.16
2007 NF PE RVU: 5.87 **2009 NF PE RVU:** 5.97
2007 Fac PE RVU:0.37 **2009 Fac PE RVU:**0.43

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. **CPT Action? (if applicable):**

72126 **Computed tomography, cervical spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 20,456

2007 Work RVU: 1.22 **2009 Work RVU:** 1.22
2007 NF PE RVU: 7.1 **2009 NF PE RVU:** 7.37
2007 Fac PE RVU:0.39 **2009 Fac PE RVU:**0.45

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

72127 **Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 1,865

2007 Work RVU: 1.27 **2009 Work RVU:** 1.27
2007 NF PE RVU: 8.89 **2009 NF PE RVU:** 9.28
2007 Fac PE RVU:0.41 **2009 Fac PE RVU:**0.46

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. **CPT Action? (if applicable):**

72128 **Computed tomography, thoracic spine; without contrast material**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 74,945

2007 Work RVU: 1.16 **2009 Work RVU:** 1.16
2007 NF PE RVU: 5.87 **2009 NF PE RVU:** 5.95
2007 Fac PE RVU:0.37 **2009 Fac PE RVU:**0.43

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. **CPT Action? (if applicable):**

72129 **Computed tomography, thoracic spine; with contrast material**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 8,694

2007 Work RVU: 1.22 **2009 Work RVU:** 1.22
2007 NF PE RVU: 7.1 **2009 NF PE RVU:** 7.37
2007 Fac PE RVU:0.39 **2009 Fac PE RVU:**0.46

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. **CPT Action? (if applicable):**

72130 **Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 1,157

2007 Work RVU: 1.27 **2009 Work RVU:** 1.27
2007 NF PE RVU: 8.88 **2009 NF PE RVU:** 9.3
2007 Fac PE RVU:0.41 **2009 Fac PE RVU:**0.47

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

72131 **Computed tomography, lumbar spine; without contrast material** | **Global:** XXX | **Issue:** CT Spine | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: February 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR, ASNR | **First Identified:** February 2009 | **2007 Medicare Utilization Data:** 287,416

2007 Work RVU: 1.16 | **2009 Work RVU:** 1.16
2007 NF PE RVU: 5.87 | **2009 NF PE RVU:** 5.94
2007 Fac PE RVU:0.37 | **2009 Fac PE RVU:**0.43

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. | **CPT Action? (if applicable):**

72132 **Computed tomography, lumbar spine; with contrast material** | **Global:** XXX | **Issue:** CT Spine | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: February 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR | **First Identified:** February 2009 | **2007 Medicare Utilization Data:** 56,556

2007 Work RVU: 1.22 | **2009 Work RVU:** 1.22
2007 NF PE RVU: 7.1 | **2009 NF PE RVU:** 7.36
2007 Fac PE RVU:0.39 | **2009 Fac PE RVU:**0.46

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. | **CPT Action? (if applicable):**

72133 **Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections** | **Global:** XXX | **Issue:** CT Spine | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: February 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR | **First Identified:** February 2009 | **2007 Medicare Utilization Data:** 3,968

2007 Work RVU: 1.27 | **2009 Work RVU:** 1.27
2007 NF PE RVU: 8.93 | **2009 NF PE RVU:** 9.29
2007 Fac PE RVU:0.41 | **2009 Fac PE RVU:**0.47

RUC Recommendation: The RUC recommends that the entire family of CT spine services (72125-72133) be surveyed. | **CPT Action? (if applicable):**

72191 **Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing** | **Global:** XXX | **Issue:** CT Angiography | **Screen:** High Volume Growth / CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: April 2008 | **Tab** 57 | **Specialty Developing Recommendation:** ACR | **First Identified:** February 2008 | **2007 Medicare Utilization Data:** 97,992

2007 Work RVU: 1.81 | **2009 Work RVU:** 1.81
2007 NF PE RVU: 11.57 | **2009 NF PE RVU:** 10.91
2007 Fac PE RVU:0.58 | **2009 Fac PE RVU:**0.68

RUC Recommendation: Review September 2011 | **CPT Action? (if applicable):**

72192 **Computed tomography, pelvis; without contrast material** | **Global:** XXX | **Issue:** CT Pelvis | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: October 2008 | **Tab** 26 | **Specialty Developing Recommendation:** ACR | **First Identified:** October 2008 | **2007 Medicare Utilization Data:** 1,741,896

2007 Work RVU: 1.09 | **2009 Work RVU:** 1.09
2007 NF PE RVU: 5.77 | **2009 NF PE RVU:** 5.66
2007 Fac PE RVU:0.35 | **2009 Fac PE RVU:**0.41

RUC Recommendation: Refer to CPT | **CPT Action? (if applicable):** June 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

72194 **Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections** | **Global:** XXX | **Issue:** CT Pelvis | **Screen:** Codes Reported Together / CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: February 2008 | **Tab** S | **Specialty Developing Recommendation:** | **First Identified:** February 2008 | **2007 Medicare Utilization Data:** 493,901

RUC Recommendation: Refer to CPT | **CPT Action? (if applicable):** June 2009

2007 Work RVU: 1.22	2009 Work RVU: 1.22
2007 NF PE RVU: 8.67	2009 NF PE RVU: 9.32
2007 Fac PE RVU:0.39	2009 Fac PE RVU:0.45

73200 **Computed tomography, upper extremity; without contrast material** | **Global:** XXX | **Issue:** CT Upper Extremity | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: April 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR | **First Identified:** October 2008 | **2007 Medicare Utilization Data:** 62,367

RUC Recommendation: The RUC recommends that this service be surveyed | **CPT Action? (if applicable):**

2007 Work RVU: 1.09	2009 Work RVU: 1.09
2007 NF PE RVU: 5.15	2009 NF PE RVU: 5.69
2007 Fac PE RVU:0.35	2009 Fac PE RVU:0.4

73201 **Computed tomography, upper extremity; with contrast material(s)** | **Global:** XXX | **Issue:** CT Upper Extremity | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: April 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR | **First Identified:** February 2009 | **2007 Medicare Utilization Data:** 6,869

RUC Recommendation: The RUC recommends that this service be surveyed | **CPT Action? (if applicable):**

2007 Work RVU: 1.16	2009 Work RVU: 1.16
2007 NF PE RVU: 6.21	2009 NF PE RVU: 7.03
2007 Fac PE RVU:0.37	2009 Fac PE RVU:0.43

73202 **Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections** | **Global:** XXX | **Issue:** CT Upper Extremity | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: April 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR | **First Identified:** February 2009 | **2007 Medicare Utilization Data:** 1,633

RUC Recommendation: The RUC recommends that this service be surveyed | **CPT Action? (if applicable):**

2007 Work RVU: 1.22	2009 Work RVU: 1.22
2007 NF PE RVU: 7.99	2009 NF PE RVU: 9.38
2007 Fac PE RVU:0.39	2009 Fac PE RVU:0.45

73218 **Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)** | **Global:** XXX | **Issue:** MRI | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: February 2009 | **Tab** 38 | **Specialty Developing Recommendation:** ACR, ACRh | **First Identified:** October 2008 | **2007 Medicare Utilization Data:** 32,025

RUC Recommendation: CPT Assistant; Review September 2011 | **CPT Action? (if applicable):** CPT Asst - SS draft Apr 21, 2009. Need addl input

2007 Work RVU: 1.35	2009 Work RVU: 1.35
2007 NF PE RVU: 11.81	2009 NF PE RVU: 13.31
2007 Fac PE RVU:0.43	2009 Fac PE RVU:0.48

Status Report: CMS Requests and Five-Year Review ID WG Issues

73221 **Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)** **Global:** XXX **Issue:** MRI **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 474,405

2007 Work RVU: 1.35 **2009 Work RVU:** 1.35
2007 NF PE RVU: 11.55 **2009 NF PE RVU:** 12.47
2007 Fac PE RVU:0.43 **2009 Fac PE RVU:**0.49

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

73510 **Radiologic examination, hip, unilateral; complete, minimum of two views** **Global:** XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,613,137

2007 Work RVU: 0.21 **2009 Work RVU:** 0.21
2007 NF PE RVU: 0.6 **2009 NF PE RVU:** 0.66
2007 Fac PE RVU:0.07 **2009 Fac PE RVU:**0.08

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

73580 **Radiologic examination, knee, arthrography, radiological supervision and interpretation** **Global:** XXX **Issue:** Contrast X-Ray of Knee Joint **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 13,617

2007 Work RVU: 0.54 **2009 Work RVU:** 0.54
2007 NF PE RVU: 2.5 **2009 NF PE RVU:** 2.39
2007 Fac PE RVU:0.17 **2009 Fac PE RVU:**0.2

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

73610 **Radiologic examination, ankle; complete, minimum of three views** **Global:** XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,152,259

2007 Work RVU: 0.17 **2009 Work RVU:** 0.17
2007 NF PE RVU: 0.55 **2009 NF PE RVU:** 0.58
2007 Fac PE RVU:0.06 **2009 Fac PE RVU:**0.06

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

73630 **Radiologic examination, foot; complete, minimum of three views** **Global:** XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,077,247

2007 Work RVU: 0.17 **2009 Work RVU:** 0.17
2007 NF PE RVU: 0.54 **2009 NF PE RVU:** 0.57
2007 Fac PE RVU:0.06 **2009 Fac PE RVU:**0.06

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

73700 **Computed tomography, lower extremity; without contrast material** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 160,175

2007 Work RVU: 1.09 **2009 Work RVU:** 1.09
2007 NF PE RVU: 5.15 **2009 NF PE RVU:** 5.7
2007 Fac PE RVU:0.35 **2009 Fac PE RVU:**0.4

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

73701 **Computed tomography, lower extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 44,181

2007 Work RVU: 1.16 **2009 Work RVU:** 1.16
2007 NF PE RVU: 6.23 **2009 NF PE RVU:** 7.08
2007 Fac PE RVU:0.37 **2009 Fac PE RVU:**0.44

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

73702 **Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2007 Medicare Utilization Data:** 4,219

2007 Work RVU: 1.22 **2009 Work RVU:** 1.22
2007 NF PE RVU: 8.01 **2009 NF PE RVU:** 9.4
2007 Fac PE RVU:0.39 **2009 Fac PE RVU:**0.46

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

73706 **Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing** **Global:** XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 22,311

2007 Work RVU: 1.9 **2009 Work RVU:** 1.9
2007 NF PE RVU: 10.99 **2009 NF PE RVU:** 11.32
2007 Fac PE RVU:0.62 **2009 Fac PE RVU:**0.74

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

74170 **Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** Computed Tomography **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,156,894

2007 Work RVU: 1.4 **2009 Work RVU:** 1.4
2007 NF PE RVU: 9.15 **2009 NF PE RVU:** 10.78
2007 Fac PE RVU:0.45 **2009 Fac PE RVU:**0.52

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

74175 **Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 169,135

2007 Work RVU: 1.9 **2009 Work RVU:** 1.9
2007 NF PE RVU: 11.78 **2009 NF PE RVU:** 11.58
2007 Fac PE RVU:0.61 **2009 Fac PE RVU:**0.72

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

75635 **Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 79,956

2007 Work RVU: 2.4 **2009 Work RVU:** 2.4
2007 NF PE RVU: 14.78 **2009 NF PE RVU:** 12.83
2007 Fac PE RVU:0.78 **2009 Fac PE RVU:**0.95

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

75790 **Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation**

Global: XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 227,164

2007 Work RVU: 1.84 **2009 Work RVU:** 1.84
2007 NF PE RVU: 1.62 **2009 NF PE RVU:** 2.2
2007 Fac PE RVU:0.58 **2009 Fac PE RVU:**0.63

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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75791 **Angiography, arteriovenous shunt (dialysis fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation**

Global: XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.71 **CPT Action? (if applicable):**

75885 **Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2007 Medicare Utilization Data:** 302

2007 Work RVU: 1.44 **2009 Work RVU:** 1.44
2007 NF PE RVU: 10.08 **2009 NF PE RVU:** 5.15
2007 Fac PE RVU:0.46 **2009 Fac PE RVU:**0.56

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

75887 **Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation** **Global:** XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2007 Medicare Utilization Data:** 298

2007 Work RVU: 1.44 **2009 Work RVU:** 1.44
2007 NF PE RVU: 10.13 **2009 NF PE RVU:** 5.21
2007 Fac PE RVU:0.47 **2009 Fac PE RVU:**0.56

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

75992 **Transluminal atherectomy, peripheral artery, radiological supervision and interpretation** **Global:** XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 26,578

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0
2007 Fac PE RVU:0.2 **2009 Fac PE RVU:**0.22

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 2009-Postponed to Oct 2009

75993 **Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 9,508

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0
2007 Fac PE RVU:0.14 **2009 Fac PE RVU:**0.14

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 2009-Postponed to Oct 2009

75994 **Transluminal atherectomy, renal, radiological supervision and interpretation** **Global:** XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 449

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0
2007 Fac PE RVU:0.5 **2009 Fac PE RVU:**0.36

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 2009-Postponed to Oct 2009

75995 **Transluminal atherectomy, visceral, radiological supervision and interpretation** **Global:** XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 26

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0
2007 Fac PE RVU:0.48 **2009 Fac PE RVU:**0.48

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 2009-Postponed to Oct 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

75996 **Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 11

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0
2007 Fac PE RVU:0.13 **2009 Fac PE RVU:**0.13

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** Feb 2009-Postponed to Oct 2009

76100 **Radiologic examination, single plane body section (eg, tomography), other than with urography** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Review PE **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2007 Medicare Utilization Data:** 6,546

2007 Work RVU: 0.58 **2009 Work RVU:** 0.58
2007 NF PE RVU: 1.74 **2009 NF PE RVU:** 2.8
2007 Fac PE RVU:0.19 **2009 Fac PE RVU:**0.21

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

76101 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Review PE **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2007 Medicare Utilization Data:** 501

2007 Work RVU: 0.58 **2009 Work RVU:** 0.58
2007 NF PE RVU: 2.31 **2009 NF PE RVU:** 4.21
2007 Fac PE RVU:0.19 **2009 Fac PE RVU:**0.2

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

76102 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Review PE **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2007 Medicare Utilization Data:** 615

2007 Work RVU: 0.58 **2009 Work RVU:** 0.58
2007 NF PE RVU: 3.16 **2009 NF PE RVU:** 5.93
2007 Fac PE RVU:0.19 **2009 Fac PE RVU:**0.19

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

76513 **Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy** **Global:** XXX **Issue:** Ophthalmic Ultrasound **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAO, ASCRS (cataract) **First Identified:** February 2008 **2007 Medicare Utilization Data:** 20,082

2007 Work RVU: 0.66 **2009 Work RVU:** 0.66
2007 NF PE RVU: 1.47 **2009 NF PE RVU:** 1.3
2007 Fac PE RVU:0.28 **2009 Fac PE RVU:**0.24

RUC Recommendation: 0.66, CPT Assistant Article **CPT Action? (if applicable):** June 2008, requested CPT Asst to reemphasize issue

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Status Report: CMS Requests and Five-Year Review ID WG Issues

76536 **Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation** **Global:** XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2007 Medicare Utilization Data:** 476,884

2007 Work RVU: 0.56 **2009 Work RVU:** 0.56
2007 NF PE RVU: 1.66 **2009 NF PE RVU:** 2.19
2007 Fac PE RVU:0.17 **2009 Fac PE RVU:**0.19

RUC Recommendation: 0.56 **CPT Action? (if applicable):**

76880 **Ultrasound, extremity, nonvascular, real time with image documentation** **Global:** XXX **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** APMA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 192,255

2007 Work RVU: 0.59 **2009 Work RVU:** 0.59
2007 NF PE RVU: 1.79 **2009 NF PE RVU:** 2.56
2007 Fac PE RVU:0.18 **2009 Fac PE RVU:**0.19

RUC Recommendation: Review October 2009 for physician work and practice expense **CPT Action? (if applicable):**

76970 **Ultrasound study follow-up (specify)** **Global:** XXX **Issue:** Ultrasound Study Follow-up **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACS, ACR, AACE **First Identified:** February 2008 **2007 Medicare Utilization Data:** 11,924

2007 Work RVU: 0.4 **2009 Work RVU:** 0.4
2007 NF PE RVU: 1.28 **2009 NF PE RVU:** 1.69
2007 Fac PE RVU:0.13 **2009 Fac PE RVU:**0.12

RUC Recommendation: Remove from screen - RUC articulated concerns to CMS regarding claims reporting **CPT Action? (if applicable):**

77301 **Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications** **Global:** XXX **Issue:** Radiotherapy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2007 Medicare Utilization Data:** 84,814

2007 Work RVU: 7.99 **2009 Work RVU:** 7.99
2007 NF PE RVU: 34.66 **2009 NF PE RVU:** 47.21
2007 Fac PE RVU:2.59 **2009 Fac PE RVU:**2.72

RUC Recommendation: CPT Assistant; Review September 2011 **CPT Action? (if applicable):** CPT Assistant - Aug 2009

77371 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based** **Global:** XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:** 50

2007 Work RVU: **2009 Work RVU:** 0.00
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

77418 **Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session**

Global: XXX **Issue:** IMRT **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,086,301

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 16.8 **2009 NF PE RVU:** 14.20
2007 Fac PE RVU: NA **2009 Fac PE RVU:** NA

RUC Recommendation: CPT Assistant; Review September 2011 **CPT Action? (if applicable):** CPT Assistant - Aug 2009

77427 **Radiation treatment management, five treatments**

Global: XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2007 **2007 Medicare Utilization Data:** 1,309,276

2007 Work RVU: 3.7 **2009 Work RVU:** 3.7
2007 NF PE RVU: 1.15 **2009 NF PE RVU:** 1.35
2007 Fac PE RVU: 1.15 **2009 Fac PE RVU:** 1.35

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

77781 **Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters**

Global: XXX **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2007 Medicare Utilization Data:** 29,221

2007 Work RVU: 1.21 **2009 Work RVU:**
2007 NF PE RVU: 16.23 **2009 NF PE RVU:**
2007 Fac PE RVU: 0.5 **2009 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2008 - Deleted

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77782 **Remote afterloading high intensity brachytherapy; 5-8 source positions or catheters**

Global: XXX **Issue:** Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2007 Medicare Utilization Data:** 8,046

2007 Work RVU: 2.04 **2009 Work RVU:**
2007 NF PE RVU: 18.17 **2009 NF PE RVU:**
2007 Fac PE RVU: 0.77 **2009 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2008 - Deleted

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77785 **Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

Global: XXX **Issue:** High Dose Rate Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 21 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 1.42
2007 NF PE RVU: 0 **2009 NF PE RVU:** 3.05
2007 Fac PE RVU: 0 **2009 Fac PE RVU:** 0.49

RUC Recommendation: 1.42 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

77786 **Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels** **Global:** XXX **Issue:** High Dose Rate Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 21 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 3.25
2007 NF PE RVU: 0 **2009 NF PE RVU:** 10.72
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.04

RUC Recommendation: 3.25 **CPT Action? (if applicable):**

77787 **Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels** **Global:** XXX **Issue:** High Dose Rate Brachytherapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 21 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 4.89
2007 NF PE RVU: 0 **2009 NF PE RVU:** 15.7
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.71

RUC Recommendation: 4.89 **CPT Action? (if applicable):**

78451 **Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)** **Global:** **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 1.40 **CPT Action? (if applicable):**

78452 **Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection** **Global:** **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 1.75 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

78453 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 1.00 **CPT Action? (if applicable):**

78454 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:**
2007 NF PE RVU: 0 **2009 NF PE RVU:**
2007 Fac PE RVU:0 **2009 Fac PE RVU:**

RUC Recommendation: 1.34 **CPT Action? (if applicable):**

78460 **Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 0.86
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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78461 **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**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 1.23
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

Status Report: CMS Requests and Five-Year Review ID WG Issues

78464 **Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:** 1.09
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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78465 **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**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,165,546

2007 Work RVU: 1.46 **2009 Work RVU:** 1.46
2007 NF PE RVU: 11.51 **2009 NF PE RVU:** 10.64
2007 Fac PE RVU: 0.57 **2009 Fac PE RVU:** 0.68

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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78478 **Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,133,387

2007 Work RVU: 0.5 **2009 Work RVU:** 0.5
2007 NF PE RVU: 1.31 **2009 NF PE RVU:** 0.79
2007 Fac PE RVU: 0.23 **2009 Fac PE RVU:** 0.24

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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78480 **Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,117,295

2007 Work RVU: 0.3 **2009 Work RVU:** 0.3
2007 NF PE RVU: 1.31 **2009 NF PE RVU:** 0.79
2007 Fac PE RVU: 0.2 **2009 Fac PE RVU:** 0.17

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** October 2008 - Deleted

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88300 **Level I - Surgical pathology, gross examination only**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2007 Medicare Utilization Data:** 216,584

2007 Work RVU: 0.08 **2009 Work RVU:** 0.08
2007 NF PE RVU: 0.46 **2009 NF PE RVU:** 0.51
2007 Fac PE RVU: 0.03 **2009 Fac PE RVU:** 0.03

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

88302 **Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2007 Medicare Utilization Data:** 122,768

2007 Work RVU: 0.13 **2009 Work RVU:** 0.13
2007 NF PE RVU: 1.04 **2009 NF PE RVU:** 1.14
2007 Fac PE RVU:0.06 **2009 Fac PE RVU:**0.04

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

88304 **Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head; other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,200,314

2007 Work RVU: 0.22 **2009 Work RVU:** 0.22
2007 NF PE RVU: 1.29 **2009 NF PE RVU:** 1.38
2007 Fac PE RVU:0.08 **2009 Fac PE RVU:**0.07

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

88305 **Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 17,171,735

2007 Work RVU: 0.75 **2009 Work RVU:** 0.75
2007 NF PE RVU: 1.67 **2009 NF PE RVU:** 1.81
2007 Fac PE RVU: 0.3 **2009 Fac PE RVU:** 0.25

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

88307 **Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2007 Medicare Utilization Data:** 875,959

2007 Work RVU: 1.59 **2009 Work RVU:** 1.59
2007 NF PE RVU: 2.85 **2009 NF PE RVU:** 3.51
2007 Fac PE RVU:0.63 **2009 Fac PE RVU:**0.54

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

88309 **Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2007 Medicare Utilization Data:** 185,106

2007 Work RVU: 2.8 **2009 Work RVU:** 2.8
2007 NF PE RVU: 3.92 **2009 NF PE RVU:** 4.83
2007 Fac PE RVU:0.94 **2009 Fac PE RVU:**0.89

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

88312 **Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,310,001

2007 Work RVU: 0.54 **2009 Work RVU:** 0.54
2007 NF PE RVU: 1.55 **2009 NF PE RVU:** 1.97
2007 Fac PE RVU:0.21 **2009 Fac PE RVU:**0.17

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

88313 **Special stains (List separately in addition to code for primary service); Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,167,035

2007 Work RVU: 0.24 **2009 Work RVU:** 0.24
2007 NF PE RVU: 1.33 **2009 NF PE RVU:** 1.65
2007 Fac PE RVU:0.09 **2009 Fac PE RVU:**0.07

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

88314 **Special stains (List separately in addition to code for primary service); histochemical staining with frozen section(s)**

Global: XXX **Issue:** Pathology Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2007 Medicare Utilization Data:** 23,152

2007 Work RVU: 0.45 **2009 Work RVU:** 0.45
2007 NF PE RVU: 1.86 **2009 NF PE RVU:** 1.78
2007 Fac PE RVU:0.18 **2009 Fac PE RVU:**0.15

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

90465 **Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2007 Medicare Utilization Data:** 1,033

2007 Work RVU: 0.17 **2009 Work RVU:** 0.17
2007 NF PE RVU: 0.35 **2009 NF PE RVU:** 0.40
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

90467 **Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2007 Medicare Utilization Data:** 3

2007 Work RVU: 0.17 **2009 Work RVU:** 0.17
2007 NF PE RVU: 0.17 **2009 NF PE RVU:** 0.20
2007 Fac PE RVU:0.09 **2009 Fac PE RVU:**0.08

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

90471 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,076,082

2007 Work RVU: 0.17 **2009 Work RVU:** 0.17
2007 NF PE RVU: 0.35 **2009 NF PE RVU:** 0.40
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

90472 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 57,120

2007 Work RVU: 0.15 **2009 Work RVU:** 0.15
2007 NF PE RVU: 0.13 **2009 NF PE RVU:** 0.13
2007 Fac PE RVU:0.11 **2009 Fac PE RVU:**0.06

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

90473 **Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2007 Medicare Utilization Data:** 129

2007 Work RVU: 0.17 **2009 Work RVU:** 0.17
2007 NF PE RVU: 0.18 **2009 NF PE RVU:** 0.20
2007 Fac PE RVU:0.06 **2009 Fac PE RVU:**0.05

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

90474 **Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2007 Medicare Utilization Data:** 46

2007 Work RVU: 0.15 **2009 Work RVU:** 0.15
2007 NF PE RVU: 0.09 **2009 NF PE RVU:** 0.09
2007 Fac PE RVU:0.05 **2009 Fac PE RVU:**0.05

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

90935 **Hemodialysis procedure with single physician evaluation**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** RPA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,613,258

2007 Work RVU: 1.22 **2009 Work RVU:** 1.22
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.64 **2009 Fac PE RVU:**0.58

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

90937 **Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:** 105,666

2007 Work RVU: 2.11 **2009 Work RVU:** 2.11
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.93 **2009 Fac PE RVU:**0.84

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

90945 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:** 144,151

2007 Work RVU: 1.28 **2009 Work RVU:** 1.28
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.66 **2009 Fac PE RVU:**0.59

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

90947 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:** 17,394

2007 Work RVU: 2.16 **2009 Work RVU:** 2.16
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:0.94 **2009 Fac PE RVU:**0.86

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

90951 **End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 18.46
2007 NF PE RVU: 0 **2009 NF PE RVU:** 7.60
2007 Fac PE RVU:0 **2009 Fac PE RVU:**7.60

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

90952 **with 2-3 face-to-face physician visits per month** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0.00
2007 Fac PE RVU:0 **2009 Fac PE RVU:**0.00

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90953 **with 1 face-to-face physician visit per month** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0.00
2007 Fac PE RVU:0 **2009 Fac PE RVU:**0.00

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90954 **End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 15.98
2007 NF PE RVU: 0 **2009 NF PE RVU:** 5.31
2007 Fac PE RVU:0 **2009 Fac PE RVU:**5.31

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90955 **with 2-3 face-to-face physician visits per month** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 8.79
2007 NF PE RVU: 0 **2009 NF PE RVU:** 3.29
2007 Fac PE RVU:0 **2009 Fac PE RVU:**3.29

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90956 **with 1 face-to-face physician visit per month** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 5.95
2007 NF PE RVU: 0 **2009 NF PE RVU:** 2.24
2007 Fac PE RVU:0 **2009 Fac PE RVU:**2.24

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

90957 **End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 12.52
2007 NF PE RVU: 0 **2009 NF PE RVU:** 4.62
2007 Fac PE RVU:0 **2009 Fac PE RVU:**4.62

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90958 **with 2-3 face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 8.34
2007 NF PE RVU: 0 **2009 NF PE RVU:** 3.23
2007 Fac PE RVU:0 **2009 Fac PE RVU:**3.23

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90959 **with 1 face-to-face physician visit per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 5.5
2007 NF PE RVU: 0 **2009 NF PE RVU:** 2.10
2007 Fac PE RVU:0 **2009 Fac PE RVU:**2.10

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90960 **End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 5.18
2007 NF PE RVU: 0 **2009 NF PE RVU:** 2.46
2007 Fac PE RVU:0 **2009 Fac PE RVU:**2.46

RUC Recommendation: RUC Recommended revised physician and clinical staff time **CPT Action? (if applicable):**

90961 **with 2-3 face-to-face physician visits per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 4.26
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.90
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.90

RUC Recommendation: RUC Recommended revised physician and clinical staff time **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

90962 **with 1 face-to-face physician visit per month** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 3.15
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.30
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.30

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90963 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 10.56
2007 NF PE RVU: 0 **2009 NF PE RVU:** 4.14
2007 Fac PE RVU:0 **2009 Fac PE RVU:**4.14

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90964 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 9.14
2007 NF PE RVU: 0 **2009 NF PE RVU:** 3.08
2007 Fac PE RVU:0 **2009 Fac PE RVU:**3.08

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

90965 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 8.69
2007 NF PE RVU: 0 **2009 NF PE RVU:** 2.95
2007 Fac PE RVU:0 **2009 Fac PE RVU:**2.95

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

90966 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over** **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 4.26
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.83
2007 Fac PE RVU:0 **2009 Fac PE RVU:**1.83

RUC Recommendation: RUC Recommended revised clinical staff time **CPT Action? (if applicable):**

92135 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral** **Global:** XXX **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 6,608,875

2007 Work RVU: 0.35 **2009 Work RVU:** 0.35
2007 NF PE RVU: 0.65 **2009 NF PE RVU:** 0.66
2007 Fac PE RVU:0.14 **2009 Fac PE RVU:**0.14

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

92136 **Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation** **Global:** XXX **Issue:** Ophthalmologic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO, AOA, ASCRS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,086,392

2007 Work RVU: 0.54 **2009 Work RVU:** 0.54
2007 NF PE RVU: 1.37 **2009 NF PE RVU:** 1.26
2007 Fac PE RVU:0.23 **2009 Fac PE RVU:**0.22

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

92270 **Electro-oculography with interpretation and report** **Global:** XXX **Issue:** Electro-oculography **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** February 2008 **2007 Medicare Utilization Data:** 9,248

2007 Work RVU: 0.81 **2009 Work RVU:** 0.81
2007 NF PE RVU: 1.19 **2009 NF PE RVU:** 1.13
2007 Fac PE RVU:0.31 **2009 Fac PE RVU:**0.27

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** CPT Assistant - Aug 2008. Addtl Q&A June 2009

92285 **External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)** **Global:** XXX **Issue:** Ocular Photography **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 245,477

2007 Work RVU: 0.2 **2009 Work RVU:** 0.2
2007 NF PE RVU: 0.86 **2009 NF PE RVU:** 0.76
2007 Fac PE RVU:0.09 **2009 Fac PE RVU:**0.08

RUC Recommendation: The RUC recommends that this service be surveyed for physician work and practice expense. **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

92506 **Evaluation of speech, language, voice, communication, and/or auditory processing**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** **Specialty Developing Recommendation:** ASHA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Review February 2010 **CPT Action? (if applicable):**

92507 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** **Specialty Developing Recommendation:** ASHA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Review February 2010 **CPT Action? (if applicable):**

92508 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** No

Most Recent RUC Meeting: February 2010 **Tab** **Specialty Developing Recommendation:** ASHA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Review February 2010 **CPT Action? (if applicable):**

92526 **Treatment of swallowing dysfunction and/or oral function for feeding**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 39 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 7,004

2007 Work RVU: 0.55 **2009 Work RVU:** 0.55
2007 NF PE RVU: 1.65 **2009 NF PE RVU:** 1.60
2007 Fac PE RVU: 0.19 **2009 Fac PE RVU:** 0.18

RUC Recommendation: 1.34 work RVU and clinical staff time removed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

92540 **Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 1.50 **CPT Action? (if applicable):**

92541 **Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 140,717

2007 Work RVU: 0.4 **2009 Work RVU:** 0.4
2007 NF PE RVU: 0.88 **2009 NF PE RVU:** 1
2007 Fac PE RVU: 0.17 **2009 Fac PE RVU:** 0.14

RUC Recommendation: 0.40 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

92542 **Positional nystagmus test, minimum of 4 positions, with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 146,284

2007 Work RVU: 0.33 **2009 Work RVU:** 0.33
2007 NF PE RVU: 1.02 **2009 NF PE RVU:** 1.16
2007 Fac PE RVU: 0.14 **2009 Fac PE RVU:** 0.12

RUC Recommendation: 0.33 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

92543 **Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 428,692

2007 Work RVU: **2009 Work RVU:** 0.10
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 0.10 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

92544 **Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 126,682

2007 Work RVU: 0.26 **2009 Work RVU:** 0.26
2007 NF PE RVU: 0.82 **2009 NF PE RVU:** 0.94
2007 Fac PE RVU:0.11 **2009 Fac PE RVU:**0.09

RUC Recommendation: 0.26 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

92545 **Oscillating tracking test, with recording** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 146,751

2007 Work RVU: 0.23 **2009 Work RVU:** 0.23
2007 NF PE RVU: 0.75 **2009 NF PE RVU:** 0.9
2007 Fac PE RVU:0.1 **2009 Fac PE RVU:**0.08

RUC Recommendation: 0.23 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

92550 **Tympanometry and reflex threshold measurements** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 0.35 **CPT Action? (if applicable):**

92557 **Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,040,112

2007 Work RVU: 0 **2009 Work RVU:** 0.6
2007 NF PE RVU: 1.21 **2009 NF PE RVU:** 0.53
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.46

RUC Recommendation: 0.60 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

92567 **Tympanometry (impedance testing)** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 946,813

2007 Work RVU: 0 **2009 Work RVU:** 0.20
2007 NF PE RVU: 0.51 **2009 NF PE RVU:** 0.23
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.18

RUC Recommendation: 0.20 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

92568 **Acoustic reflex testing; threshold** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 354,672

2007 Work RVU: 0 **2009 Work RVU:** 0.29
2007 NF PE RVU: 0.32 **2009 NF PE RVU:** 0.17
2007 Fac PE RVU: NA **2009 Fac PE RVU:** 0.17

RUC Recommendation: 0.29 work RVU and clinical staff time removed **CPT Action? (if applicable):** February 2009

92569 **Acoustic reflex testing; decay** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 46,996

2007 Work RVU: 0 **2009 Work RVU:** 0.2
2007 NF PE RVU: 0.35 **2009 NF PE RVU:** 0.16
2007 Fac PE RVU: NA **2009 Fac PE RVU:** 0.16

RUC Recommendation: Deleted from CPT **CPT Action? (if applicable):** February 2009 - Deleted

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92570 **Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: 0.55 **CPT Action? (if applicable):**

92587 **Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)** **Global:** XXX **Issue:** Audiology Testing **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 41,868

2007 Work RVU: 0.13 **2009 Work RVU:** 0.13
2007 NF PE RVU: 1.13 **2009 NF PE RVU:** 0.77
2007 Fac PE RVU: 0.06 **2009 Fac PE RVU:** 0.05

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

92597 **Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech** **Global:** XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 30 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2007 Medicare Utilization Data:** 1,833

2007 Work RVU: 0.86 **2009 Work RVU:** 0.86
2007 NF PE RVU: 1.69 **2009 NF PE RVU:** 1.89
2007 Fac PE RVU: 0.4 **2009 Fac PE RVU:** 0.34

RUC Recommendation: 1.48 work RVU and clinical staff time removed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

92605 **Evaluation of speech, language, voice, communication, and/or auditory processing** | **Global:** XXX | **Issue:** Speech Language Pathology Services | **Screen:** CMS Request/Speech Language Pathology Request | **Complete?** No

Most Recent RUC Meeting: October 2009 | **Tab** | **Specialty Developing Recommendation:** ASHA | **First Identified:** | **2007 Medicare Utilization Data:**

2007 Work RVU: | **2009 Work RVU:**
2007 NF PE RVU: | **2009 NF PE RVU:**
2007 Fac PE RVU: | **2009 Fac PE RVU:**

RUC Recommendation: Review October 2009 | **CPT Action? (if applicable):**

92606 **Therapeutic service(s) for the use of non-speech-generating device, including programming and modification** | **Global:** XXX | **Issue:** Speech Language Pathology Services | **Screen:** CMS Request/Speech Language Pathology Request | **Complete?** No

Most Recent RUC Meeting: October 2009 | **Tab** | **Specialty Developing Recommendation:** ASHA | **First Identified:** | **2007 Medicare Utilization Data:**

2007 Work RVU: | **2009 Work RVU:**
2007 NF PE RVU: | **2009 NF PE RVU:**
2007 Fac PE RVU: | **2009 Fac PE RVU:**

RUC Recommendation: Review October 2009 | **CPT Action? (if applicable):**

92607 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour** | **Global:** XXX | **Issue:** Speech Language Pathology Services | **Screen:** CMS Request/Speech Language Pathology Request | **Complete?** No

Most Recent RUC Meeting: October 2009 | **Tab** | **Specialty Developing Recommendation:** ASHA | **First Identified:** | **2007 Medicare Utilization Data:**

2007 Work RVU: | **2009 Work RVU:**
2007 NF PE RVU: | **2009 NF PE RVU:**
2007 Fac PE RVU: | **2009 Fac PE RVU:**

RUC Recommendation: Review October 2009 | **CPT Action? (if applicable):**

92608 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)** | **Global:** XXX | **Issue:** Speech Language Pathology Services | **Screen:** CMS Request/Speech Language Pathology Request | **Complete?** No

Most Recent RUC Meeting: October 2009 | **Tab** | **Specialty Developing Recommendation:** ASHA | **First Identified:** | **2007 Medicare Utilization Data:**

2007 Work RVU: | **2009 Work RVU:**
2007 NF PE RVU: | **2009 NF PE RVU:**
2007 Fac PE RVU: | **2009 Fac PE RVU:**

RUC Recommendation: Review October 2009 | **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

92610 **Evaluation of oral and pharyngeal swallowing function** **Global:** XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 30 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 4,478

2007 Work RVU: 0 **2009 Work RVU:** 0.00
2007 NF PE RVU: 2.98 **2009 NF PE RVU:** 2.08
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: 1.30 work RVU and clinical staff time removed **CPT Action? (if applicable):**

92611 **Motion fluoroscopic evaluation of swallowing function by cine or video recording** **Global:** XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 39 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2007 Medicare Utilization Data:** 5,956

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 3.04 **2009 NF PE RVU:** 2.27
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **CPT Action? (if applicable):**

92620 **Evaluation of central auditory function, with report; initial 60 minutes** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 1,156

2007 Work RVU: 0 **2009 Work RVU:** 1.5
2007 NF PE RVU: 1.32 **2009 NF PE RVU:** 0.44
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.44

RUC Recommendation: 1.50 **CPT Action? (if applicable):**

92621 **Evaluation of central auditory function, with report; each additional 15 minutes** **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 15

2007 Work RVU: 0 **2009 Work RVU:** 0.35
2007 NF PE RVU: 0.29 **2009 NF PE RVU:** 0.10
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.10

RUC Recommendation: 0.35 **CPT Action? (if applicable):**

92625 **Assessment of tinnitus (includes pitch, loudness matching, and masking)** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 2,384

2007 Work RVU: 0 **2009 Work RVU:** 1.15
2007 NF PE RVU: 1.3 **2009 NF PE RVU:** 0.39
2007 Fac PE RVU:1.3 **2009 Fac PE RVU:**0.39

RUC Recommendation: 1.15 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

92626 **Evaluation of auditory rehabilitation status; first hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 4,667

2007 Work RVU: 0 **2009 Work RVU:** 1.4
2007 NF PE RVU: 2.11 **2009 NF PE RVU:** 0.73
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.73

RUC Recommendation: 1.40 **CPT Action? (if applicable):**

92627 **Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 684

2007 Work RVU: 0 **2009 Work RVU:** 0.33
2007 NF PE RVU: 0.52 **2009 NF PE RVU:** 0.19
2007 Fac PE RVU:0.52 **2009 Fac PE RVU:**0.19

RUC Recommendation: 0.33 **CPT Action? (if applicable):**

92640 **Diagnostic analysis with programming of auditory brainstem implant, per hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2007 Medicare Utilization Data:** 9

2007 Work RVU: 0 **2009 Work RVU:** 1.76
2007 NF PE RVU: 1.4 **2009 NF PE RVU:** 0.26
2007 Fac PE RVU:1.4 **2009 Fac PE RVU:**0.26

RUC Recommendation: 1.76 **CPT Action? (if applicable):**

92986 **Percutaneous balloon valvuloplasty; aortic valve** **Global:** 090 **Issue:** Valvuloplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 984

2007 Work RVU: 22.7 **2009 Work RVU:** 22.7
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:12.84 **2009 Fac PE RVU:**14.36

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

93005 **Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report** **Global:** XXX **Issue:** Echocardiography **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACEP **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,080,528

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.41 **2009 NF PE RVU:** 0.31
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

93017 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Test **Screen:** High Volume Growth, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 254,652

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 1.64 **2009 NF PE RVU:** 1.54
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: PE Review - no change **CPT Action? (if applicable):**

93025 **Microvolt T-wave alternans for assessment of ventricular arrhythmias**

Global: XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 18 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2007 Medicare Utilization Data:** 12,133

2007 Work RVU: 0.75 **2009 Work RVU:** 0.75
2007 NF PE RVU: 6.36 **2009 NF PE RVU:** 4.66
2007 Fac PE RVU:0.31 **2009 Fac PE RVU:**0.36

RUC Recommendation: New PE Inputs **CPT Action? (if applicable):**

93040 **Rhythm ECG, 1-3 leads; with interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2007 Medicare Utilization Data:** 151,669

2007 Work RVU: 0.16 **2009 Work RVU:** 0.16
2007 NF PE RVU: 0.2 **2009 NF PE RVU:** 0.19
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

93041 **Rhythm ECG, 1-3 leads; tracing only without interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2007 Medicare Utilization Data:** 20,099

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.15 **2009 NF PE RVU:** 0.14
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

93042 **Rhythm ECG, one to three leads; interpretation and report only**

Global: XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACEP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,334,305

2007 Work RVU: 0.16 **2009 Work RVU:** 0.16
2007 NF PE RVU: 0.05 **2009 NF PE RVU:** 0.05
2007 Fac PE RVU:0.05 **2009 Fac PE RVU:**0.05

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

93230 **Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation**

Global: XXX **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2007 Medicare Utilization Data:** 346,692

2007 Work RVU: 0.52 **2009 Work RVU:** 0.52
2007 NF PE RVU: 3.49 **2009 NF PE RVU:** 2.61
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Refer to CPT to revise code family that have work RVUs (93224-93272). **CPT Action? (if applicable):** October 2009

93233 **Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; physician review and interpretation**

Global: XXX **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule **Complete?** No

Most Recent RUC Meeting: April 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2007 Medicare Utilization Data:** 135,207

2007 Work RVU: 0.52 **2009 Work RVU:** 0.52
2007 NF PE RVU: 0.2 **2009 NF PE RVU:** 0.22
2007 Fac PE RVU:0.2 **2009 Fac PE RVU:**0.22

RUC Recommendation: Refer to CPT to revise code family that have work RVUs (93224-93272). **CPT Action? (if applicable):** October 2009

93236 **Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; monitoring and real-time data analysis with report**

Global: XXX **Issue:** Cardiovascular Stress Test **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 5,550

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0.00
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.00

RUC Recommendation: Remove from screen/Contractor Priced **CPT Action? (if applicable):**

93307 **Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete**

Global: XXX **Issue:** Cardiology Services **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2007 Medicare Utilization Data:** 7,431,827

2007 Work RVU: 0.92 **2009 Work RVU:** 0.92
2007 NF PE RVU: 3.72 **2009 NF PE RVU:** 3.3
2007 Fac PE RVU:0.38 **2009 Fac PE RVU:**0.43

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

93308 **Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study** **Global:** XXX **Issue:** Echocardiography **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 129,879

2007 Work RVU: 0.53 **2009 Work RVU:** 0.53
2007 NF PE RVU: 2.04 **2009 NF PE RVU:** 2.16
2007 Fac PE RVU:0.22 **2009 Fac PE RVU:**0.26

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

93320 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete** **Global:** ZZZ **Issue:** Cardiology Services **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2007 Medicare Utilization Data:** 7,670,710

2007 Work RVU: 0.38 **2009 Work RVU:** 0.38
2007 NF PE RVU: 1.66 **2009 NF PE RVU:** 1.48
2007 Fac PE RVU:0.16 **2009 Fac PE RVU:**0.18

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

93325 **Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)** **Global:** ZZZ **Issue:** Cardiology Services **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2007 Medicare Utilization Data:** 7,663,570

2007 Work RVU: 0.07 **2009 Work RVU:** 0.07
2007 NF PE RVU: 2.33 **2009 NF PE RVU:** 1.18
2007 Fac PE RVU:0.03 **2009 Fac PE RVU:**0.03

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

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** **Global:** XXX **Issue:** Stress Echo with ECG Monitoring **Screen:** Other - Identified by RUC **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 19 **Specialty Developing Recommendation:** ACC **First Identified:** April 2008 **2007 Medicare Utilization Data:** 445,667

2007 Work RVU: 1.48 **2009 Work RVU:** 1.46
2007 NF PE RVU: 2.4 **2009 NF PE RVU:** 3.51
2007 Fac PE RVU:0.63 **2009 Fac PE RVU:**0.72

RUC Recommendation: 1.46 **CPT Action? (if applicable):**

93510 **Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** CMS Request - Practice Expense Review/Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 880,712

2007 Work RVU: 0 **2009 Work RVU:** 4.32
2007 NF PE RVU: 0 **2009 NF PE RVU:** 27.77
2007 Fac PE RVU:2.22 **2009 Fac PE RVU:**2.28

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

93526 **Combined right heart catheterization and retrograde left heart catheterization** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 128,061

2007 Work RVU: 0 **2009 Work RVU:** 5.98
2007 NF PE RVU: 0 **2009 NF PE RVU:** 34.91
2007 Fac PE RVU: 2.93 **2009 Fac PE RVU:** 3.11

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93539 **Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 171,128

2007 Work RVU: 0.4 **2009 Work RVU:** 0.4
2007 NF PE RVU: NA **2009 NF PE RVU:** 1.81
2007 Fac PE RVU: 0.18 **2009 Fac PE RVU:** 0.20

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93540 **Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 182,504

2007 Work RVU: 0.43 **2009 Work RVU:** 0.43
2007 NF PE RVU: NA **2009 NF PE RVU:** 6.18
2007 Fac PE RVU: 0.19 **2009 Fac PE RVU:** 0.22

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93543 **Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together, CMS Request - Practice Expense Review **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 893,156

2007 Work RVU: 0.29 **2009 Work RVU:** 0.29
2007 NF PE RVU: NA **2009 NF PE RVU:** 1.90
2007 Fac PE RVU: 0.12 **2009 Fac PE RVU:** 0.14

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93544 **Injection procedure during cardiac catheterization; for aortography** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2007 Medicare Utilization Data:** 93,297

2007 Work RVU: 0.25 **2009 Work RVU:** 0.25
2007 NF PE RVU: NA **2009 NF PE RVU:** 1.34
2007 Fac PE RVU: 0.11 **2009 Fac PE RVU:** 0.13

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

93545 **Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)** **Global:** 000 **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together, CMS Request - Practice Expense Review **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,070,895

2007 Work RVU: 0.4 **2009 Work RVU:** 0.4
2007 NF PE RVU: NA **2009 NF PE RVU:** 4.22
2007 Fac PE RVU:0.18 **2009 Fac PE RVU:**0.20

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93555 **Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography** **Global:** XXX **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together, CMS Request - Practice Expense Review **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 917,846

2007 Work RVU: 0 **2009 Work RVU:** 0.81
2007 NF PE RVU: 0 **2009 NF PE RVU:** 1.69
2007 Fac PE RVU:0.35 **2009 Fac PE RVU:**0.4

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93556 **Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)** **Global:** XXX **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together, CMS Request - Practice Expense Review **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,070,500

2007 Work RVU: 0 **2009 Work RVU:** 0.83
2007 NF PE RVU: 0 **2009 NF PE RVU:** 2.79
2007 Fac PE RVU:0.36 **2009 Fac PE RVU:**0.41

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** June 2009

93613 **Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 15,425

2007 Work RVU: 6.99 **2009 Work RVU:** 6.99
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:3.03 **2009 Fac PE RVU:**3.48

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

93652 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia** **Global:** 000 **Issue:** Intracardiac Catheter Ablation **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 2,062

2007 Work RVU: 17.65 **2009 Work RVU:** 17.65
2007 NF PE RVU: NA **2009 NF PE RVU:** NA
2007 Fac PE RVU:7.58 **2009 Fac PE RVU:**8.75

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Electrocardiography **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 5,440

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0
2007 Fac PE RVU:1.22 **2009 Fac PE RVU:**1.38

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

93743 **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); dual chamber, without reprogramming**

Global: XXX **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2007 Medicare Utilization Data:** 531,090

2007 Work RVU: 1.03 **2009 Work RVU:**
2007 NF PE RVU: 0.71 **2009 NF PE RVU:**
2007 Fac PE RVU:0.44 **2009 Fac PE RVU:**

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

93922 **Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)**

Global: XXX **Issue:** Extremity Study **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC, APMA **First Identified:** October 2008 **2007 Medicare Utilization Data:** 500,746

2007 Work RVU: 0.25 **2009 Work RVU:** 0.25
2007 NF PE RVU: 2.7 **2009 NF PE RVU:** 2.86
2007 Fac PE RVU:0.08 **2009 Fac PE RVU:**0.08

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

93923 **Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)**

Global: XXX **Issue:** Extremity Study **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC, APMA **First Identified:** February 2009 **2007 Medicare Utilization Data:** 641,680

2007 Work RVU: 0.45 **2009 Work RVU:** 0.45
2007 NF PE RVU: 4.03 **2009 NF PE RVU:** 4.3
2007 Fac PE RVU:0.15 **2009 Fac PE RVU:**0.15

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

Status Report: CMS Requests and Five-Year Review ID WG Issues

93924 **Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study** **Global:** XXX **Issue:** Extremity Study **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACC, APMA **First Identified:** February 2009 **2007 Medicare Utilization Data:** 109,797

2007 Work RVU: 0.5 **2009 Work RVU:** 0.5
2007 NF PE RVU: 4.88 **2009 NF PE RVU:** 5.37
2007 Fac PE RVU:0.17 **2009 Fac PE RVU:**0.18

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** October 2009

93976 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study** **Global:** XXX **Issue:** Vasculary Study **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2007 Medicare Utilization Data:** 90,871

2007 Work RVU: 1.21 **2009 Work RVU:** 1.21
2007 NF PE RVU: 3.94 **2009 NF PE RVU:** 4.05
2007 Fac PE RVU:0.39 **2009 Fac PE RVU:**0.44

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

93990 **Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)** **Global:** XXX **Issue:** Echocardiography **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** SVS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 43,525

2007 Work RVU: 0.25 **2009 Work RVU:** 0.25
2007 NF PE RVU: 4.2 **2009 NF PE RVU:** 4.77
2007 Fac PE RVU:0.08 **2009 Fac PE RVU:**0.07

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

94014 **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 7,057

2007 Work RVU: 0.52 **2009 Work RVU:** 0.52
2007 NF PE RVU: 0.77 **2009 NF PE RVU:** 0.79
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

94015 **Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 6,245

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.61 **2009 NF PE RVU:** 0.64
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action? (if applicable):**

94016 **Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** April 2008 **2007 Medicare Utilization Data:** 22,001

2007 Work RVU: 0.52 **2009 Work RVU:** 0.52
2007 NF PE RVU: 0.16 **2009 NF PE RVU:** 0.15
2007 Fac PE RVU:0.16 **2009 Fac PE RVU:**0.15

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action? (if applicable):**

94450 **Breathing response to hypoxia (hypoxia response curve)** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 3,686

2007 Work RVU: 0.4 **2009 Work RVU:** 0.4
2007 NF PE RVU: 0.78 **2009 NF PE RVU:** 0.85
2007 Fac PE RVU:0.11 **2009 Fac PE RVU:**0.1

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action? (if applicable):**

94681 **Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** AACE, TES, ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 92,598

2007 Work RVU: 0.2 **2009 Work RVU:** 0.2
2007 NF PE RVU: 2.1 **2009 NF PE RVU:** 1.36
2007 Fac PE RVU:0.06 **2009 Fac PE RVU:**0.05

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

94760 **Noninvasive ear or pulse oximetry for oxygen saturation; single determination** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2007 Medicare Utilization Data:** 55,922

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.05 **2009 NF PE RVU:** 0.06
2007 Fac PE RVU: NA **2009 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

94761 **Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2007 Medicare Utilization Data:** 16,082

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.08 **2009 NF PE RVU:** 0.10
2007 Fac PE RVU: NA **2009 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

94762 **Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 271,032

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.56 **2009 NF PE RVU:** 0.72
2007 Fac PE RVU: NA **2009 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

94770 **Carbon dioxide, expired gas determination by infrared analyzer** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 23,034

2007 Work RVU: 0.15 **2009 Work RVU:** 0.15
2007 NF PE RVU: 0.72 **2009 NF PE RVU:** 0.74
2007 Fac PE RVU: 0.04 **2009 Fac PE RVU:** 0.04

RUC Recommendation: Remove office-based PE inputs **CPT Action? (if applicable):**

95803 **Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)** **Global:** XXX **Issue:** Actigraphy Sleep Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 34 **Specialty Developing Recommendation:** **First Identified:** NA **2007 Medicare Utilization Data:** 0

2007 Work RVU: **2009 Work RVU:** 0.00
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

95922 **Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt**

Global: XXX **Issue:** Autonomic Nerve Function Test **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACP, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 39,276

2007 Work RVU: 0.96 **2009 Work RVU:** 0.96
2007 NF PE RVU: 0.63 **2009 NF PE RVU:** 1.07
2007 Fac PE RVU:0.37 **2009 Fac PE RVU:**0.31

RUC Recommendation: CPT Assistant article; Re-review September 2011 **CPT Action? (if applicable):** CPT Assistant - December 2008

95950 **Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours**

Global: XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2007 Medicare Utilization Data:** 1,475

2007 Work RVU: 1.51 **2009 Work RVU:** 1.51
2007 NF PE RVU: 3.59 **2009 NF PE RVU:** 4.07
2007 Fac PE RVU:0.59 **2009 Fac PE RVU:**0.49

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

95953 **Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours**

Global: XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2007 Medicare Utilization Data:** 14,491

2007 Work RVU: 3.3 **2009 Work RVU:** 3.3
2007 NF PE RVU: 6.31 **2009 NF PE RVU:** 6.11
2007 Fac PE RVU:1.21 **2009 Fac PE RVU:**1.05

RUC Recommendation: The RUC recommends that this service be surveyed **CPT Action? (if applicable):**

95954 **Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)**

Global: XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ACNS, AAN **First Identified:** February 2008 **2007 Medicare Utilization Data:** 4,743

2007 Work RVU: 2.45 **2009 Work RVU:** 2.45
2007 NF PE RVU: 3.47 **2009 NF PE RVU:** 3.55
2007 Fac PE RVU:0.91 **2009 Fac PE RVU:**0.56

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

95956 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours** **Global:** XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 8,201

2007 Work RVU: 3.08 **2009 Work RVU:** 3.08
2007 NF PE RVU: 14.27 **2009 NF PE RVU:** 14.74
2007 Fac PE RVU:1.2 **2009 Fac PE RVU:**1.01

RUC Recommendation: CPT Assistant; The RUC recommends that this service be surveyed **CPT Action? (if applicable):** CPT Assistant -draft Feb 10, 2009. Need addtl info

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95991 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician** **Global:** XXX **Issue:** Brain Pump **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2007 Medicare Utilization Data:** 75,784

2007 Work RVU: 0.77 **2009 Work RVU:** 0.77
2007 NF PE RVU: 1.53 **2009 NF PE RVU:** 1.57
2007 Fac PE RVU:NA **2009 Fac PE RVU:**0.18

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

96105 **Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour** **Global:** XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** No

Most Recent RUC Meeting: October 2009 **Tab** **Specialty Developing Recommendation:** ASHA **First Identified:** **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Review October 2009 **CPT Action? (if applicable):**

96405 **Chemotherapy administration; intralesional, up to and including 7 lesions** **Global:** 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2007 Medicare Utilization Data:** 1,409

2007 Work RVU: 0.52 **2009 Work RVU:** 0.52
2007 NF PE RVU: 2.71 **2009 NF PE RVU:** 1.79
2007 Fac PE RVU:0.24 **2009 Fac PE RVU:**0.25

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

96406 **Chemotherapy administration; intralesional, more than 7 lesions** **Global:** 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2007 Medicare Utilization Data:** 400

2007 Work RVU: 0.8 **2009 Work RVU:** 0.8
2007 NF PE RVU: 3.08 **2009 NF PE RVU:** 2.40
2007 Fac PE RVU:0.29 **2009 Fac PE RVU:**0.33

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

96440 **Chemotherapy administration into pleural cavity, requiring and including thoracentesis** | **Global:** 000 | **Issue:** Chemotherapy Administration | **Screen:** CMS Request - Practice Expense Review | **Complete?** Yes

Most Recent RUC Meeting: February 2008 | **Tab** R | **Specialty Developing Recommendation:** | **First Identified:** NA | **2007 Medicare Utilization Data:** 73

2007 Work RVU: 2.37 | **2009 Work RVU:** 2.37
2007 NF PE RVU: 7.48 | **2009 NF PE RVU:** 14.04
2007 Fac PE RVU:1.17 | **2009 Fac PE RVU:**1.13

RUC Recommendation: New PE inputs | **CPT Action? (if applicable):**

96567 **Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session** | **Global:** XXX | **Issue:** Photodynamic Therapy | **Screen:** High Volume Growth / CMS Fastest Growing | **Complete?** Yes

Most Recent RUC Meeting: April 2008 | **Tab** 57 | **Specialty Developing Recommendation:** AAD | **First Identified:** February 2008 | **2007 Medicare Utilization Data:** 27,705

2007 Work RVU: 0 | **2009 Work RVU:** 0
2007 NF PE RVU: 2.4 | **2009 NF PE RVU:** 3.20
2007 Fac PE RVU:NA | **2009 Fac PE RVU:**NA

RUC Recommendation: Remove from screen | **CPT Action? (if applicable):**

96920 **Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm** | **Global:** 000 | **Issue:** Laser Skin Treatment | **Screen:** CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: October 2008 | **Tab** 26 | **Specialty Developing Recommendation:** AAD | **First Identified:** October 2008 | **2007 Medicare Utilization Data:** 23,491

2007 Work RVU: 1.15 | **2009 Work RVU:** 1.15
2007 NF PE RVU: 2.8 | **2009 NF PE RVU:** 3.27
2007 Fac PE RVU:0.57 | **2009 Fac PE RVU:**0.59

RUC Recommendation: Review September 2011 | **CPT Action? (if applicable):**

96921 **Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm** | **Global:** 000 | **Issue:** Laser Skin Treatment | **Screen:** High Volume Growth / CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: October 2008 | **Tab** 26 | **Specialty Developing Recommendation:** AAD | **First Identified:** February 2008 | **2007 Medicare Utilization Data:** 8,386

2007 Work RVU: 1.17 | **2009 Work RVU:** 1.17
2007 NF PE RVU: 2.82 | **2009 NF PE RVU:** 3.15
2007 Fac PE RVU:0.57 | **2009 Fac PE RVU:**0.55

RUC Recommendation: Review September 2011 | **CPT Action? (if applicable):**

96922 **Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm** | **Global:** 000 | **Issue:** Laser Skin Treatment | **Screen:** High Volume Growth / CMS Fastest Growing | **Complete?** No

Most Recent RUC Meeting: October 2008 | **Tab** 26 | **Specialty Developing Recommendation:** AAD | **First Identified:** October 2008 | **2007 Medicare Utilization Data:** 4,390

2007 Work RVU: 2.1 | **2009 Work RVU:** 2.1
2007 NF PE RVU: 3.77 | **2009 NF PE RVU:** 4.30
2007 Fac PE RVU:0.73 | **2009 Fac PE RVU:**0.98

RUC Recommendation: Review September 2011 | **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

97755 **Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes**

Global: XXX **Issue:** Assistive Technology Assessment **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** AAPMR, APTA, AOTA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 2,618

2007 Work RVU: 0.62 **2009 Work RVU:** 0.62
2007 NF PE RVU: 0.28 **2009 NF PE RVU:** 0.28
2007 Fac PE RVU: NA **2009 Fac PE RVU:** NA

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

97802 **Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2007 Medicare Utilization Data:** 169,902

2007 Work RVU: 0.45 **2009 Work RVU:** 0.53
2007 NF PE RVU: 0.39 **2009 NF PE RVU:** 0.27
2007 Fac PE RVU: 0.38 **2009 Fac PE RVU:** 0.22

RUC Recommendation: 0.53 **CPT Action? (if applicable):**

97803 **Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2007 Medicare Utilization Data:** 104,791

2007 Work RVU: 0.37 **2009 Work RVU:** 0.45
2007 NF PE RVU: 0.38 **2009 NF PE RVU:** 0.25
2007 Fac PE RVU: 0.38 **2009 Fac PE RVU:** 0.20

RUC Recommendation: 0.45 **CPT Action? (if applicable):**

99174 **Ocular photoscreening with interpretation and report, bilateral**

Global: XXX **Issue:** Ocular photoscreening **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 54 **Specialty Developing Recommendation:** AAP, AAO **First Identified:** NA **2007 Medicare Utilization Data:**

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0 **2009 NF PE RVU:** 0.69
2007 Fac PE RVU: 0 **2009 Fac PE RVU:** NA

RUC Recommendation: New PE inputs **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

G0179 **Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAFP, ACP, AAHCP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 1,106,055

2007 Work RVU: 0.45 **2009 Work RVU:** 0.45
2007 NF PE RVU: 0.89 **2009 NF PE RVU:** 0.61
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** ACP discussing with CMS

G0180 **Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AAFP, ACP, AAHCP **First Identified:** October 2008 **2007 Medicare Utilization Data:**

2007 Work RVU: **2009 Work RVU:**
2007 NF PE RVU: **2009 NF PE RVU:**
2007 Fac PE RVU: **2009 Fac PE RVU:**

RUC Recommendation: Refer to CPT **CPT Action? (if applicable):** ACP discussing with CMS

G0181 **Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (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 laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the 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**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAFP, ACP **First Identified:** October 2008 **2007 Medicare Utilization Data:** 287,780

2007 Work RVU: 1.73 **2009 Work RVU:** 1.73
2007 NF PE RVU: 1.32 **2009 NF PE RVU:** 0.98
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

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

G0202 **Screening mammography, producing direct digital image, bilateral, all views**

Global: XXX **Issue:** Digital Mammography **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 1,966,397

2007 Work RVU: 0.7 **2009 Work RVU:** 0.7
2007 NF PE RVU: 2.52 **2009 NF PE RVU:** 2.56
2007 Fac PE RVU:0.22 **2009 Fac PE RVU:**0.24

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

Status Report: CMS Requests and Five-Year Review ID WG Issues

G0204 **Diagnostic mammography, producing direct digital image, bilateral, all views** **Global:** XXX **Issue:** Digital Mammography **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 281,851

2007 Work RVU: 0.87 **2009 Work RVU:** 0.87
2007 NF PE RVU: 2.6 **2009 NF PE RVU:** 2.96
2007 Fac PE RVU:0.27 **2009 Fac PE RVU:**0.29

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

G0206 **Diagnostic mammography, producing direct digital image, unilateral, all views** **Global:** XXX **Issue:** Digital Mammography **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2007 Medicare Utilization Data:** 325,174

2007 Work RVU: 0.7 **2009 Work RVU:** 0.7
2007 NF PE RVU: 2.09 **2009 NF PE RVU:** 2.33
2007 Fac PE RVU:0.22 **2009 Fac PE RVU:**0.24

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

G0237 **Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)** **Global:** XXX **Issue:** Respiratory Therapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 106,168

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.41 **2009 NF PE RVU:** 0.27
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action? (if applicable):**

G0238 **Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)** **Global:** XXX **Issue:** Respiratory Therapy **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2007 Medicare Utilization Data:** 145,686

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 0.43 **2009 NF PE RVU:** 0.29
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **CPT Action? (if applicable):**

G0249 **Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; per 4 tests** **Global:** XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth / CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 26,718

2007 Work RVU: 0 **2009 Work RVU:** 0
2007 NF PE RVU: 3.57 **2009 NF PE RVU:** 3.49
2007 Fac PE RVU:NA **2009 Fac PE RVU:**NA

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

Status Report: CMS Requests and Five-Year Review ID WG Issues

G0250 **Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service)**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth **Complete?** No

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2007 Medicare Utilization Data:** 4,079

2007 Work RVU: 0.18 **2009 Work RVU:** 0.18
2007 NF PE RVU: 0.07 **2009 NF PE RVU:** 0.08
2007 Fac PE RVU: NA **2009 Fac PE RVU:** NA

RUC Recommendation: Review September 2011 **CPT Action? (if applicable):**

G0268 **Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing**

Global: 000 **Issue:** Removal of Wax **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2007 Medicare Utilization Data:** 94,645

2007 Work RVU: 0.61 **2009 Work RVU:** 0.61
2007 NF PE RVU: 0.63 **2009 NF PE RVU:** 0.66
2007 Fac PE RVU: 0.23 **2009 Fac PE RVU:** 0.22

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

G0270 **Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nurtition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ADA **First Identified:** February 2008 **2007 Medicare Utilization Data:** 5,993

2007 Work RVU: 0.37 **2009 Work RVU:** 0.37
2007 NF PE RVU: 0.38 **2009 NF PE RVU:** 0.25
2007 Fac PE RVU: 0.38 **2009 Fac PE RVU:** 0.20

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

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

RUC Referrals to CPT Editorial Panel

Code	Screen	RUC Review Date	Specialty	Background	CPT Meeting & Tab
11040	Site of Service Anomaly	September 2007	ACS, AAOS	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.	Feb 09 Tab 5 resulting in CPT Excision and Debridement Workgroup Formed
11041	Site of Service Anomaly	September 2007	ACS, AAOS	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.	Feb 09 Tab 5 resulting in CPT Excision and Debridement Workgroup Formed
11042	Site of Service Anomaly	September 2007	ACS, AAOS	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.	Feb 09 Tab 5 resulting in CPT Excision and Debridement Workgroup Formed
11043	Site of Service Anomaly	September 2007	ACS, AAOS	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.	Feb 09 Tab 5 resulting in CPT Excision and Debridement Workgroup Formed
11044	Site of Service Anomaly	September 2007	ACS, AAOS	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.	Feb 09 Tab 5 resulting in CPT Excision and Debridement Workgroup Formed
14300	Site of Service Anomaly / CMS Fastest Growing	October 2008	ACS, AAD, ASPS, AAO-HNS	The specialty society commented that the descriptor does not accurately describe the work that may be involved in this service. Specifically, the work that is involved in performing the procedure in one area of the body may vary greatly from the work that is involved in performing the procedure in other areas of the body. The specialty society recommended and the RUC agreed that the code be referred to the CPT Editorial Panel for revision.	Feb 09 Tab 9 Code Deleted

15740	Site of Service Anomaly / CMS Fastest Growing	April 2008	AAD, ASPS	CPT code 15740 was identified through the RUC's Five Year Review Identification Workgroup as a site of service anomaly in September 2007. After discussion amongst the specialties that provide the service, there was confusion as to how this service, as described, was performed in the office and hospital setting. All societies agreed that this service needed clarification and recommended forwarding the code to CPT to better delineate instructions as to how to code this service properly, and develop a CPT assistant article to assist in coding properly. The society plans to create a code change proposal for introductory language to be published in the CPT, and provide its membership with instructions and clarification in coding as well. The RUC recommends CPT code 15740 be referred to the CPT Editorial Panel for instructional language development to be submitted by July 23, 2008. The physician time will be reverted back to its original physician time components in place prior to the RUC's Five Year Review Identification Workgroup's site of service anomalies activities. Feb 2009, CPT added introductory language to clarify reporting.	Feb 09 Tab 11 Complete
19357	Site of Service Anomaly	April 2009	ASPS	Originally referred to CPT because of differences in delayed and immediate breast reconstruction enables a bi-modal typical patient. Specialty requests RUC reconsider referral. In April 2009 Workgroup reviewed this issue and reaffirmed its original recommendation that this code be referred to CPT. Given its bi-modal distribution, code 19357 may be separated into two separate codes to describe interval and immediate reconstruction.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
20005	Site of Service Anomaly	September 2007	ACS, APMA	Refer to CPT to consider description change to clarify target. The dominant specialties are not consistent because deep abscess is unlikely to be performed in the office	June 09 Tab 15
21015	Site of Service Anomaly	September 2007	ACS, AAOS, AAO-HNS, ASPS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
21557	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
21935	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete

22554	Codes Reported Together	February 2008	AANS/CNS, NASS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. CPT proposal to be submitted by November 5, 2008	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
22849	CMS Fastest Growing	February 2009	AAOS, NASS, AANS	The Workgroup recommends that the specialty develop changes to the CPT instructions and/or parenthetical to limit reporting with other procedures.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
22851	CMS Fastest Growing	October 2008	AAOS, NASS, AANS	The Workgroup agreed that this service was potentially misvalued and asks that either the service be revised at CPT to bundle with the base code or may need to be resurveyed.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
22900	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
23076	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
26080	Site of Service Anomaly	February 2008	ASSH, AAOS	A majority of these services are performed in the out-patient hospital setting, though the survey respondents overwhelmingly state that the service is always performed as an in-patient procedure. The only variance among respondents was the length of stay which was estimated to be between one and six days. Based on these differences, the specialty society concluded and the RUC agreed that there is no appropriate typical patient for the code as currently described. The RUC concurred that greater granularity of the CPT descriptor is a more appropriate path.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
27048	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
27370	High Volume Growth / CMS Fastest Growing	February 2009	AAOS, ACR	These procedures were referred to CPT for possible deletion of 73580 and 27370 and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes.	SS will submit coding proposal by July 15 for October 09 CPT Mtg

27615	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
27619	Site of Service Anomaly	September 2007	ACS, AAOS	CPT developed new coding structure for soft tissue tumor procedures.	June 08 Tab 06 New code structure complete
27640	Site of Service Anomaly	February 2008	AOFAS, AAOS	CPT Editorial Panel addressed in June 2008 by clarifying that 27635 should be used for exostosis excision, leaving 27640 and 27641 with typical patients requiring an inpatient stay	June 08 Tab 07 Complete
27641	Site of Service Anomaly	February 2008	AOFAS, AAOS	CPT Editorial Panel addressed in June 2008 by clarifying that 27635 should be used for exostosis excision, leaving 27640 and 27641 with typical patients requiring an inpatient stay	June 08 Tab 07 Complete
29220	High Volume Growth	April 2008	AAFP	The specialty society was unable to identify any physician that performs this service and recommended to the Workgroup that the service be referred to the CPT Editorial Panel for deletion. The Workgroup accepts the action plan of the specialty society and recommends that 29220 be referred to the CPT Editorial Panel for possible deletion. Specialty society to prepare CPT coding change proposal to delete code.	Oct 08 Tab 10 Code Deleted
33213	CMS Fastest Growing	October 2008	ACC	The RUC discovered that this service was billed 76% of the time with the removal code, despite the fact that 33213 describes an insertion or replacement. The RUC agrees that this is inappropriate and recommends that the service be referred to CPT for revision of the descriptor and/or instructions.	
35470	CMS Fastest Growing	October 2008	ACC, ACR, SIR	The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
35471	CMS Fastest Growing			The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
35472	CMS Fastest Growing			The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting

.35473	CMS Fastest Growing			The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
35474	CMS Fastest Growing	October 2008	ACC, ACR, SIR	The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
35475	CMS Fastest Growing			The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
35476	CMS Fastest Growing			The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services). Percutaneous atherectomy and angioplasty will both be reviewed by CPT.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
35490	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 – Postponed to Oct 09 CPT Mtg
35491	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 – Postponed to Oct 09 CPT Mtg
35492	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 – Postponed to Oct 09 CPT Mtg
35493	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 – Postponed to Oct 09 CPT Mtg
35494	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 – Postponed to Oct 09 CPT Mtg
35495	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 – Postponed to Oct 09 CPT Mtg

36145	Codes Reported Together	February 2008	ACR	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - proposal by Nov 2008. Code was deleted and replaced with new codes to report arteriovenous shunt access imaging coming to April 2009 RUC meeting under arteriovenous shunt imaging tab.	Feb 09 Tab 31 Code Deleted
36248	CMS Fastest Growing	October 2008	ACR, SIR	The code is part of a component coding structure. It should be reviewed by CPT along with the other services reported together (bundled services)	SS to develop coding proposal by July 15 for Oct 09 CPT mtg
36834	Site of Service Anomaly	September 2007	SVS, ACS	The RUC referred the service to CPT for clarification of the "plastic repair" language within the descriptor	Feb 09 Tab 18 Code Deleted
37760	Site of Service Anomaly	September 2007	SVS, ACS	The RUC referred the service to CPT for clarification of the descriptor and asked the specialty to consider creation of code for minor perforator ligation	Feb 09 Tab 19 Complete
45170	Site of Service Anomaly	February 2008	ACS, ASCRS, ASGS	CPT code 45170 Excision of rectal tumor, transanal approach was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society requested that this service be referred to the CPT Editorial Panel to distinguish the size of the tumor as the removal of different size tumors would reflect different patient populations and different physician work. Further the descriptor should be clarified to indicate that this service represents a full thickness excision of the rectal wall which can result in several patient complications including pelvic sepsis, urinary retention, hemorrhage and rectal/vaginal fistulas. For these reasons, the RUC recommends that 45170 be referred to the CPT Editorial Panel.	Oct 08 Tab 18 Code Deleted
47490	CMS Fastest Growing	February 2009	ACR	This service was referred to CPT to include a code to include guidance. The number of hospital visits varies widely among physicians (i.e., who is managing post-operative care) and it would be more appropriate to change this service to a 000 day global procedure. The Workgroup recommends that it be valued as a 000 day global procedure.	June 09 Tab 17

49420	Site of Service Anomaly	April 2008	ACS	At the April 2008 RUC meeting, the specialty society requested that codes 49420 and 49421 be referred to the CPT Editorial Panel for clarification. The specialty society is concerned that the original intention of these descriptors has changed over time because of the addition of new catheter codes. Additionally, the specialty society indicated that some inadvertent miscoding may be occurring because the descriptor is vague with respect to catheter placement for "drainage" and whether the code is meant for open or percutaneous placement. The RUC recommends that codes 49420 and 49421 be referred to the CPT Editorial Panel for clarification.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
49421	Site of Service Anomaly	April 2008	ACS	At the April 2008 RUC meeting, the specialty society requested that codes 49420 and 49421 be referred to the CPT Editorial Panel for clarification. The specialty society is concerned that the original intention of these descriptors has changed over time because of the addition of new catheter codes. Additionally, the specialty society indicated that some inadvertent miscoding may be occurring because the descriptor is vague with respect to catheter placement for "drainage" and whether the code is meant for open or percutaneous placement. The RUC recommends that codes 49420 and 49421 be referred to the CPT Editorial Panel for clarification.	SS will submit coding proposal by July 15 for Oct 09 CPT Meeting
51726	Codes Reported Together	February 2008	AUA	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - proposal by Nov 2008. Deleted 51772 and 51795, revised 51797 and added three new codes to combine the services.	Feb 09 Tab 24 Complete
51772	Codes Reported Together / CMS Fastest Growing	February 2008	AUA	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - proposal by Nov 2008. Deleted 51772 and 51795, revised 51797 and added three new codes to combine the services.	Feb 09 Tab 24 Code Deleted
51795	Codes Reported Together	February 2008	AUA	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - proposal by Nov 2008. Deleted 51772 and 51795, revised 51797 and added three new codes to combine the services.	Feb 09 Tab 24 Code Deleted
51797	Codes Reported Together	February 2008	AUA	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - proposal by Nov 2008. Deleted 51772 and 51795, revised 51797 and added three new codes to combine the services.	Feb 09 Tab 24 Code Revised

55866	New Technology / CMS Fastest Growing	February 2008	AUA	The specialty society reported that it will submit coding change proposals to the CPT Editorial Panel to request new CPT codes. Code 55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing will remain. Additional CPT coding change proposals will be submitted for the following: 5586X *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing; with total pelvic lymphadenectomy* and 5586X *Laparoscopy, robotic assisted surgical prostatectomy, retropubic radical, including nerve sparing*, and 5586X, *with total pelvic lymphadenectomy*, in time for discussion at the February 2009 CPT Editorial Panel Meeting. In February 2008 the Five-Year Review Identification Workgroup recommended that the specialty society develop a coding proposal to separate code 55866 into two codes to distinguish between robotic and non-robotic laparoscopic prostatectomy. The CPT Editorial Panel determined that the codes should be surveyed and describe the typical method and not separated into two codes. The Workgroup recommends that 55866 be reviewed at the October 2009 RUC meeting. The Workgroup indicated that it is at the discretion of the society if they wish to revise the vignette and resurvey 55866 or utilize survey data from last year.	RUC review Oct 09
57155	Site of Service Anomaly	September 2007	ACOG, ASTRO	ACOG conducted original survey however, service is performed by radiation oncologists 83% if the time. The typical patient may have changed requiring modification to the descriptor	SS will submit coding proposal by July 15 for October 09 CPT Mtg
61795	CMS Fastest Growing	February 2009	NASS, AAO-HNS, AANS	The specialty commented that the descriptor does not accurately describe the work and recommends that the service be referred to CPT to create several more granular codes. The Workgroup agreed and recommends that the service be referred to CPT.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
61885	Site of Service Anomaly	February 2009	AANS/CNS	The RUC approved the specialty society recommendation to refer to CPT	SS will submit coding proposal by July 15 for October 09 CPT Mtg
63056	CMS Fastest Growing	February 2009	NASS, AANS	The specialty noted that the increase in utilization may be due to some inappropriate reporting of procedures that should be described using 62287 and another procedure that does not have a CPT code. The Workgroup recommends referral to CPT for changes to the instructions and possible creation of a new CPT code.	SS will submit coding proposal by July 15 for October 09 CPT Mtg

63075	Codes Reported Together	February 2008	AANS/CNS, NASS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. CPT proposal to be submitted by November 5, 2008	SS will submit coding proposal by July 15 for October 09 CPT Mtg
63660	Site of Service Anomaly / CMS Fastest Growing	February 2008	AAPM, AANS/CNS, ASA, ISIS, NASS	The RUC recommend that this code be referred to the CPT Editorial Panel to more clearly define the service as the current CPT descriptor makes this code difficult to survey and value, i.e. the descriptor includes remove or revise.	Oct 08 Tab 19 Code Deleted
64416	Site of Service Anomaly	September 2007	ASA	The RUC recommended change to 000 global for accuracy & consistency of valuation; change in descriptor is necessary as it implies a different global. Change in descriptors & globals for entire family is necessary for uniformity and accuracy.	Feb 08 Tab 31 Complete
64446	Site of Service Anomaly / High Volume Growth	September 2007	ASA	The RUC recommended change to 000 global for accuracy & consistency of valuation; change in descriptor is necessary as it implies a different global. Change in descriptors & globals for entire family is necessary for uniformity and accuracy.	Feb 08 Tab 31 Complete
64448	Site of Service Anomaly / High Volume Growth / CMS Fastest Growing	September 2007	ASA	The RUC recommended change to 000 global for accuracy & consistency of valuation; change in descriptor is necessary as it implies a different global. Change in descriptors & globals for entire family is necessary for uniformity and accuracy.	Feb 08 Tab 31 Complete
64449	Site of Service Anomaly	September 2007	ASA	The RUC recommended change to 000 global for accuracy & consistency of valuation; change in descriptor is necessary as it implies a different global. Change in descriptors & globals for entire family is necessary for uniformity and accuracy.	Feb 08 Tab 31 Complete
64470	High Volume Growth	April 2008	ASA, NASS, AAPM, ISIS	The RUC recommended that the specialty develop a coding change proposal to include work that was once a part of the add-on service but is now typically performed with the base code within the base code.	Feb 09 Tab 28 Code Deleted
64472	High Volume Growth	April 2008	ASA, NASS, AAPM, ISIS	The RUC recommended that the specialty develop a coding change proposal to include work that was once a part of the add-on service but is now typically performed with the base code within the base code.	Feb 09 Tab 28 Code Deleted
64475	High Volume Growth	April 2008	ASA, NASS, AAPM, ISIS	The RUC recommended that the specialty develop a coding change proposal to include work that was once a part of the add-on service but is now typically performed with the base code within the base code.	Feb 09 Tab 28 Code Deleted
64476	High Volume Growth	April 2008	ASA, NASS, AAPM, ISIS	The RUC recommended that the specialty develop a coding change proposal to include work that was once a part of the add-on service but is now typically performed with the base code within the base code.	Feb 08 Tab 28 Code Deleted

64483	CMS Fastest Growing	October 2008	AAPM, ISIS, ASA, NASS, AAPMR	The RUC recommended that this service along with the other codes in its family (64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484) be referred to CPT to be bundled with the appropriate guidance procedure(s).	June 09 Tab 19
64484	CMS Fastest Growing	October 2008	AAPM, ISIS, ASA, NASS, AAPMR	The Workgroup recommended that this service along with the other codes in its family (64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484) be referred to CPT to be bundled with the appropriate guidance procedure(s).	June 09 Tab 19
64573	Site of Service Anomaly	February 2009	AANS/CNS	RUC approved the specialty society recommendation to refer to CPT.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
64581	Site of Service Anomaly	April 2008	AUA	Specialty to develop coding change proposal	SS will submit coding proposal by July 15 for Oct 09 CPT Mtg
64622	High Volume Growth / CMS Fastest Growing	April 2008	ASA, NASS, AAPM, ISIS	CPT Executive Committee addressed on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.	May 08 EC- B Complete
64623	High Volume Growth	April 2008	ASA, NASS, AAPM, ISIS	CPT Executive Committee addressed on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.	May 08 EC- B Complete
64626	High Volume Growth / CMS Fastest Growing	April 2008	ASA, NASS, AAPM, ISIS	CPT Executive Committee addressed on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.	May 08 EC- B Complete
64627	High Volume Growth / CMS Fastest Growing	April 2008	ASA, NASS, AAPM, ISIS	CPT Executive Committee addressed on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.	May 08 EC- B Complete
64712	Site of Service Anomaly	April 2008	AOFAS, ASSH, AAOS, ASPS	The specialty society has identified this as a CPT issue requiring new codes for catheter injection, not only of the sciatic nerve, but also of the lumbar plexus (ie, code 64714) which also appears to have the same shift in reporting since the introduction of the Racz catheter. The RUC agreed and recommended that this service be referred to the CPT Editorial Panel for revision.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
66761	High IWPUT	April 2009	ASCRS (cataract), AAO	In April 2009 the Workgroup determined that the specialty society should clarify and re-requet that CMS change 66761 to a 010-day global period. However, if the global period change is not acceptable, the specialty society should develop a coding proposal to clarify.	
67210	High IWPUT	April 2008	AAO	Specialty to develop coding change proposal. Thereafter, RUC will request CMS to change global to 010 and subsequent survey	5 Year ID Workgroup Item – Oct 09

67220	High IWPUT	April 2008	AAO	Specialty to develop coding change proposal. Thereafter, RUC will request CMS to change global to 010 and subsequent survey	5 Year ID Workgroup Item – Oct 09
67228	High IWPUT	April 2008	AAO	Specialty to develop coding change proposal. Thereafter, RUC will request CMS to change global to 010 and subsequent survey	5 Year ID Workgroup Item – Oct 09
72192	CMS Fastest Growing	October 2008	ACR	The specialty society indicated that this service is included within the specialties review of Bundled services. The RUC agreed and recommends that the service be addressed through a revision of the CPT code.	June 09 Tab 38
72194	Codes Reported Together / CMS Fastest Growing	February 2008	ACR	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. CPT proposal to be submitted by November 5, 2008	June 09 Tab 38
73580	High Volume Growth / CMS Fastest Growing	February 2009	AAOS, ACR	These procedures were referred to CPT for possible deletion of 73580 and 27370 and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
74170	Codes Reported Together	February 2008	ACR	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. CPT proposal to be submitted by November 5, 2008	June 09 Tab 38
74175	CMS Fastest Growing	October 2008	ACR	RUC requested that it be reviewed by CPT to consider the appropriateness of component coding and other services it may be typically performed with.	June 09 Tab 38
75790	Codes Reported Together	February 2008	ACR	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. CPT proposal to be submitted by November 5, 2008	Feb 09 Tab 31 Code Deleted
75992	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 - Postponed to Oct 09 CPT Mtg
75993	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 - Postponed to Oct 09 CPT Mtg

75994	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 - Postponed to Oct 09 CPT Mtg
75995	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 - Postponed to Oct 09 CPT Mtg
75996	High Volume Growth	April 2008	SIR, ACR, SVS	The RUC recommended that a CPT coding change proposal be developed to address the changing technology, which accounts for some of the growth in volume	Feb 09 Tab 17 - Postponed to Oct 09 CPT Mtg
76513	High Volume Growth	April 2008	AAO, ASCatRS	CPT Executive Committee addressed on May 1 and added parenthetical to instruct not to report 76513 where 0187T is appropriate. Specialty to develop CPT Assistant article. The specialty has requested to re-emphasize this issue.	May 08 EC- F Complete
77427	Site of Service Anomalies	October 2008	ASTRO	The RUC Research Subcommittee discussed the development of a modified survey instrument for this service and commented that the coding structure of 77427 does not adequately reflect the practice of this service and that perhaps the code needs to return to the CPT Editorial Panel to address the perceived different levels of intensity of providing this service. The specialty agreed and will bring forward a coding change proposal in March 2009 for the June 2009 CPT Meeting	June 09 Tab 21
77782	High Volume Growth / CMS Fastest Growing	February 2008	ASTRO	Deleted from CPT at February 2008 CPT Editorial Panel Meeting	Feb 08 Tab 36 Code Deleted
78465	Codes Reported Together	February 2008	SNM/ACR/AAC/ASNC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - Type A codes are bi-directionally paired. That is, when Code 1 is reported, Code 2 is also reported greater than the threshold % of occurrences and when Code 2 is reported, Code 1 is also reported greater than the threshold % of occurrences. Subsequently, these two codes are submitted independently "rarely". Foremost, the workgroup will ask specialties to consider coding change proposals to condense each Type A code pair into a single code and eliminate the original two codes.	Oct 08 Tab 23 Code Deleted

78478	Codes Reported Together	February 2008	SNM/ACR/ACC/ASNC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - Type A codes are bi-directionally paired. That is, when Code 1 is reported, Code 2 is also reported greater than the threshold % of occurrences and when Code 2 is reported, Code 1 is also reported greater than the threshold % of occurrences. Subsequently, these two codes are submitted independently "rarely". Foremost, the workgroup will ask specialties to consider coding change proposals to condense each Type A code pair into a single code and eliminate the original two codes.	Oct 08 Tab 23 Code Deleted
78480	Codes Reported Together	February 2008	SNM/ACR/ACC/ASNC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - Type A codes are bi-directionally paired. That is, when Code 1 is reported, Code 2 is also reported greater than the threshold % of occurrences and when Code 2 is reported, Code 1 is also reported greater than the threshold % of occurrences. Subsequently, these two codes are submitted independently "rarely". Foremost, the workgroup will ask specialties to consider coding change proposals to condense each Type A code pair into a single code and eliminate the original two codes.	Oct 08 Tab 23 Code Deleted
78483	High Volume Growth	February 2008	SNM/ACR/ACC/ASNC	Referral to CPT for deletion, clarification, or revision and to explore the possibility of increased use caused by billing this service in conjunction with CPT 78465.	Oct 08 Tab 23 Code Deleted
92541	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship.	Feb 09 Tab 54 Complete
92542	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship.	Feb 09 Tab 54 Complete
92544	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship.	Feb 09 Tab 54 Complete
92545	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship.	Feb 09 Tab 54 Complete

92557	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship.	Feb 09 Tab 54 Complete
92567	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship.	Feb 09 Tab 54 Complete
92568	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship.	Feb 09 Tab 54 Complete
92569	Codes Reported Together	February 2008	AAO-HNS	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship.	Feb 09 Tab 54 Code Deleted
92587	CMS Fastest Growing		AAO-HNS	The specialty noted that this is now a very useful test for a wider range of patients. Previously, these patients were diagnosed via MRI, whereas this service is less expensive. The Workgroup recommends that this service be referred to CPT and subsequently surveyed for physician work and practice expense be reviewed.	June 09 Tab 27
93236	High Volume Growth	February 2008	ACC	In February 2008 the Workgroup recommended referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume. In April 2009, the Workgroup recommended that code 93236 be removed from the high volume growth screen as it is carrier priced and does not have work or practice expense RVUs.	Removed from screen
93510	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93526	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28

93539	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93540	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93543	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93544	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type B code - code pair is reported together greater than 95% in a unidirectional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93545	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93555	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28
93556	Codes Reported Together	February 2008	ACC	Referred to the CPT Editorial Panel for development of coding change proposals to condense pairs into a single code and create new coding structures. Type A code - code pair is reported together greater than 95% in a bi-directional relationship. Specialty is to submit CPT proposal by March 4 2009 for the June 2009 CPT meeting.	June 09 Tab 28

93922	CMS Fastest Growing	February 2009	ACC, APMA	The Workgroup accepted the specialty recommendation to refer these services to CPT as there are a number of examples included in the code descriptor. The entire family of services (93922, 93923, 93924) are recommended to be referred to CPT.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
93923	CMS Fastest Growing	February 2009	ACC, APMA	The Workgroup accepted the specialty recommendation to refer these services to CPT as there are a number of examples included in the code descriptor. The entire family of services (93922, 93923, 93924) are recommended to be referred to CPT.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
93924	CMS Fastest Growing	February 2009	ACC, APMA	The Workgroup accepted the specialty recommendation to refer these services to CPT as there are a number of examples included in the code descriptor. The entire family of services (93922, 93923, 93924) are recommended to be referred to CPT.	SS will submit coding proposal by July 15 for October 09 CPT Mtg
G0179	CMS Fastest Growing	October 2008	AAFP, ACP, AAHCP	The Workgroup agreed that this service would be more appropriately reported with a CPT Category I code.	ACP discussing with CMS
G0180	CMS Fastest Growing	October 2008	AAFP, ACP, AAHCP	G0180 was identified as part of the code family to be reviewed with G0179. The Workgroup agreed that this service would be more appropriately reported with a CPT Category I code.	ACP discussing with CMS

RUC Recommendations to Develop CPT Assistant Articles

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	CMS Fastest Growing	Apr-09	Review September 2011	AAD	The Workgroup believed that 13120, 13121, and 13122 were regularly performed at the same time as excision of lesion services and may need to be referred to CPT to create bundled services. However, the specialty society provided a robust analysis of utilization data showing that this family of codes is not typically reported by the same physician at the time of any excision codes. The Workgroup recommends that this service be reviewed again in 2 years. The Workgroup recommends that the specialty develop a CPT Assistant article to provide correct coding instructions. Prior to this identification screen, SS submitted a CPT Assistant article on this issue in Aug 2006. In April 2009 the RUC reviewed the 2006 article and determined that it did not sufficiently address the current issue or have any impact on Medicare utilization. **The Workgroup recommends that another CPT Assistant article be written to address this issue, specifically focusing on the second and higher volume code.**	
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	CMS Fastest Growing	Apr-09	Review September 2011	AAD	The Workgroup believed that 13120, 13121, and 13122 were regularly performed at the same time as excision of lesion services and may need to be referred to CPT to create bundled services. However, the specialty society provided a robust analysis of utilization data showing that this family of codes is not typically reported by the same physician at the time of any excision codes. The Workgroup recommends that this service be reviewed again in 2 years. The Workgroup recommends that the specialty develop a CPT Assistant article to provide correct coding instructions.	

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
						Prior to this identification screen, SS submitted a CPT Assistant article on this issue in Aug 2006. In April 2009 the RUC reviewed the 2006 article and determined that it did not sufficiently address the current issue or have any impact on Medicare utilization. **The Workgroup recommends that another CPT Assistant article be written to address this issue, specifically focusing on the second and higher volume code.**	
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	CMS Fastest Growing	Apr-09	Review September 2011	AAD	The Workgroup believed that 13120, 13121, and 13122 were regularly performed at the same time as excision of lesion services and may need to be referred to CPT to create bundled services. However, the specialty society provided a robust analysis of utilization data showing that this family of codes is not typically reported by the same physician at the time of any excision codes. The Workgroup recommends that this service be reviewed again in 2 years. The Workgroup recommends that the specialty develop a CPT Assistant article to provide correct coding instructions. Prior to this identification screen, SS submitted a CPT Assistant article on this issue in Aug 2006. In April 2009 the RUC reviewed the 2006 article and determined that it did not sufficiently address the current issue or have any impact on Medicare utilization. **The Workgroup recommends that another CPT Assistant article be written to address this issue, specifically focusing on the second and higher volume code.**	
20005	Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated	Site of Service Anomalies	Sep-07	Refer to CPT	ACS, APMA	Refer to CPT to consider description change to clarify target - dominant specialty followed closely by podiatry does not make sense because deep abscess is unlikely to be done in office; Request CPT Assistant to publish an article on correct coding. The specialty commented that they believe the Medicare database, which indicates that	SS submitted coding proposal for review at CPT June 09 meeting

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
						podiatrists represent 23% of the providers is not reflective of the general population requiring this service and incorrectly reduces this service to slightly below 50% inpatient. They believe the typical patient is staying in the facility and the discrepancy in site-of-service data is caused by normal statistical variation and/or incorrect claim forms.	
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	CMS Fastest Growing	Oct-08	CPT Asst Article	AAOS, NASS, AANS	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to draft a CPT Assistant article. The article should include the other services in the family, 22532 and 22534.	SS to submit article to CPT by June 2009
29220	Strapping; low back	High Volume Growth	Apr-08	Refer to CPT	AAFP	Specialty society to prepare CPT coding change proposal to delete code. This code change proposal is under consideration at the October 2008 CPT Meeting. The specialty should consider the impact of the April 2002 CPT Assistant on the utilization of this service.	Deleted at Oct 2008 CPT meeting – no further action necessary.
36516	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion	CMS Fastest Growing	Oct-08	CPT Asst Article	ACP, ASH	The Workgroup noted that this was a new service in 2002 and has relatively low volume. The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article to clarify coding.	Submitted CPT Assistant article Mar 25, 2009 To be published in August 2009
43236	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance	CMS Fastest Growing	Oct-08	Review September 2011	ACG, AGA, ASGE	Develop CPT Assistant article and look at volume again in 3 years	April 2009
43242	Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)	CMS Fastest Growing	Oct-08	Review September 2011	ACG, AGA, ASGE	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.	March 2009

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
43259	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate	CMS Fastest Growing	Oct-08	Review September 2011	ACG, AGA, ASGE	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.	March 2009
45381	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance	CMS Fastest Growing	Oct-08	Review September 2011	ACG, AGA, ASGE	The Workgroup agreed with the specialty society's rationale for volume growth and recommended that a CPT Assistant article be drafted to discuss the gastroenterology services. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.	March 2009
50605	Ureterotomy for insertion of indwelling stent, all types	CMS Fastest Growing	Oct-08	Refer to CPT	AUA	Urologists are not typically the primary physician and are not performing the opening or closing, and descriptor of physician work should reflect this.	Date of Article received 4-8-09 To be published in July 2009
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	High Volume Growth	Oct-08	Review September 2011	AUA	In April 2008, RUC recommends CPT Assistant article; review again in 2 years; and review for PE	Submitted CPT Assistant article Apr 8, 2009 To be published in September 2009
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	High Volume Growth	Oct-08	Review September 2011	AUA	In April 2008, RUC recommends CPT Assistant article; review again in 2 years; and review for PE	Submitted CPT Assistant article Apr 8, 2009 To be published in September 2009
64555	Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)	High Volume Growth / CMS Fastest Growing	Feb-08	Refer to CPT, Review in September 2011	ISIS, AAPMR, AANS, AUA	Develop CPT Assistant article and/or review of the impact of previous CPT Assistant articles on volume.	Submitted CPT Assistant article Apr 8, 2009 To be published in October 2009

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
65780	Ocular surface reconstruction; amniotic membrane transplantation	CMS Fastest Growing	Oct-08	CPT Asst Article	AAO, ASCRS	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting.	June 2009
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	High IWPUT / CMS Fastest Growing	Apr-08	Reduce to 2x99213 and 3x99212; Review in September 2011	AAO, ASCRS (cataract), AOA (optometry)	Post-service office visits less intense than surveyed (5x99213). Reduce to 2x99213 & 3x99212 to reduce disparate IWPUT between 66982 and 66984. Specialty society work with CMS to develop better defined criteria for accurate reporting of 66982, including a CPT Assistant article. The specialty should also review the 2003 CPT Assistant article to determine if this clarification impacted the reporting of this service.	CPT Staff and SS working on article to be published on Sep 2009
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	CMS Fastest Growing	Feb-09	Review September 2011	ACR	ACR indicated that some of the utilization growth replaces other services (e.g., 78585). Also, some of the growth may be due to miscoding of coronary CTA studies and development of Category III codes in 2008 should eliminate this coding. Further, the procedure was recently reviewed by the RUC in 2001. The Workgroup recommends that the specialty draft an informational article in CPT Assistant article and a comparable ACR publication and review the service again in 2 years (September 2011).	Submitted CPT Assistant article mar 20, 2009. To be published June 2009.
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	CMS Fastest Growing	Feb-09	Review September 2011	ACR, ACRh	The specialties commented that the increase in utilization is most likely due to inappropriate coding. Rheumatologists have been reporting this service incorrectly and should instead use 73221. The Workgroup recommends that ACRh publish an article within their coding publication and draft a CPT Assistant Q&A. The Workgroup also recommends that it review this service as well as 73221 again in two years (September 2011).	Submitted CPT Assistant article Apr 21, 2009. Additional ACR input needed.

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy	High Volume Growth	Apr-08	Refer to CPT	AAO, ASCRS (cataract)	CPT Executive Committee addressed on May 1 and added parenthetical to instruct not to report 76513 where 0187T is appropriate. Specialty to develop CPT Assistant article.	Parenthetical addressed and specialty requested CPT Assistant to reemphasize issue
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	CMS Fastest Growing	Oct-08	Review September 2011	ASTRO	Develop CPT Assistant article and look at volume again in 3 years	Submitted draft of article March 20, 2009 To be published in August 2009
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	CMS Fastest Growing	Oct-08	Review September 2011	ASTRO	Develop CPT Assistant article and look at volume again in 3 years	Submitted draft of article March 20, 2009 To be published in August 2009
92270	Electro-oculography with interpretation and report	High Volume Growth	Feb-08	Refer to CPT	AAO, AOA (opt)	Specialty to develop CPT Assistant article to clarify appropriate coding.	Article published in August 2008 CPT Assistant. Additional Q&A to be published June 2009. To be published in June 2009
93236	Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated, monitoring and real-time data analysis with report	High Volume Growth	Apr-09	Refer to CPT. Review in 2 years. Remove from screen	ACC	Referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume. Also review the change in utilization after two years of additional data.	RUC removed from the high volume growth screen as it is carrier priced and does not have work or practice expense RVUs. No further action necessary.

Code	Descriptor	Screen	Date	Recommendation	Specialty	Background	CPT Asst Status
95922	Testing of autonomic nervous system function: vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt	High Volume Growth / CMS Fastest Growing	Apr-08	CPT Assistant article; Review September 2011	ACP, AAN	Recommend that CPT Assistant publish article on correct coding and review in two years (April 2010)	December 2008
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours	CMS Fastest Growing	Oct-08 Feb-09	RUC recommends that this service be surveyed	AAN	Develop CPT Assistant article and RUC will discuss need for survey at the February 2009 meeting	Submitted draft of article Feb 10, 2009. Draft of article reviewed by Board, sent back to specialty to address comments.

Physician Time for RUC Recommendations for CPT Cycle 2010

CPT Code	Global Period	Pre-Service Evaluation	Pre Service Positioning	Pre Service Srub Dress and Wait	Intra Service	Immediate Post	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
14301	090	33	10	15	100	25						0.5			1	3			287
14302	ZZZ				40														40
21011	090	22	6		30	10									1	1			107
21012	090	19	6	5	45	15						0.5			1	1			148
21013	090	33	8	15	45	15						0.5			1	1			174
21014	090	33	8	15	60	20						0.5			1	2			217
21015	090	40	8	20	75	30						0.5			1	3			277
21016	090	40	8	20	100	30			1	1		1			1	2	1		398
21552	090	33	3	15	60	25						0.5			1	1			194
21554	090	40	20	20	90	30			1			1			1	2			320
21555	090	19	6	5	35	15						0.5			1	1			138
21556	090	33	20	15	60	25						0.5			1	2			234
21557	090	40	12	20	113	30			1	1		1			1	3			398
21558	090	40	12	20	160	30			1	2		1			1	2	1		502
21930	090	14	18	10	45	20						0.5			1	1			165
21931	090	33	20	15	60	20						0.5			1	1			206
21932	090	33	20	15	75	20			1			1			2	1			276
21933	090	40	20	20	90	25			1			1			1	2			315
21935	090	40	20	20	120	25			1	1		1			1	3			408
21936	090	40	20	20	160	30			1	2		1			1	2	1		510
22900	090	33	3	15	60	20			1			1			2	1			244
22901	090	33	3	15	90	30			1			1			2	1			284
22902	090	14	1	10	45	20						0.5			1	1			148
22903	090	33	3	15	50	20						0.5			1	1			179
22904	090	40	3	20	120	30			1	1		1			1	3			396
22905	090	40	3	20	150	30			2	1		1			1	2	1		463
23071	090	33	20	15	45	20						0.5			1	1			191
23073	090	33	12	15	75	30			1			1			1	2			285
23075	090	14	10	10	30	20						0.5			1	1			142
23076	090	33	12	15	60	20						0.5			1	2			221
23077	090	40	20	20	140	30			1	1		1			1	3			433
23078	090	40	20	20	180	30			1	1		1			1	2	1		490
23200	090	40	12	20	155	30			1	2		1			1	2	1		497
23210	090	40	20	20	210	30			1	2		1			1	2	1		560
23220	090	40	12	20	240	30			2	2		1			1	2	1		602
24071	090	33	12	15	45	20						0.5			1	1			183
24073	090	33	20	15	75	20			1			1			1	2			283
24075	090	14	10	10	30	20						0.5			1	1			142
24076	090	33	20	15	60	20						0.5			1	2			229
24077	090	40	12	20	120	30			1	1		1			1	3			405
24079	090	40	12	20	150	30			2	1		1			1	2	1		472
24150	090	40	12	20	180	30			2	1		1			1	2	1		502
24152	090	33	12	15	150	30			1	1		1			1	2	1		440
25071	090	33	12	15	45	15						0.5			1	1			178
25073	090	33	12	15	60	20						0.5			1	2			221
25075	090	14	10	10	30	15						0.5			1	1			137
25076	090	33	12	15	45	20						0.5			1	2			206
25077	090	40	12	20	100	30			1			1			1	3			345
25078	090	40	12	20	120	30			1	1		1			1	2	1		422
25170	090	33	12	15	180	30			1	1		1			1	2	1		470
26111	090	33	12	15	40	15						0.5			1	1			173
26113	090	33	12	15	58	15						0.5			1	2			214
26115	090	14	10	10	30	15						0.5			1	1			137
26116	090	33	12	15	45	15						0.5			1	2			201
26117	090	40	12	20	75	20						0.5			1	3			271
26118	090	40	12	20	100	20			1			1			2	2	1		368
26250	090	23	10	15	120	25			1			1			1	2	1		353
26260	090	23	10	15	90	20						0.5			1	1	1		256
26262	090	14	10	10	60	20						0.5			1	1	1		212
26480	090	33	9	15	60	15						0.5			3	1			222
27043	090	33	20	15	60	20						0.5			1	1			206

Physician Time for RUC Recommendations for CPT Cycle 2010

CPT Code	Global Period	Pre-Service Evaluation	Pre Service Positioning	Pre Service Srub Dress and Wait	Intra Service	Immediate Post	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
27045	090	40	20	20	90	30			1			1			1	2			320
27047	090	14	18	10	40	20						0.5			1	1			160
27048	090	40	20	20	75	20			1			1			2	1			288
27049	090	40	3	20	180	30			1	2		1			1	3			496
27059	090	40	3	20	220	45			3	2		1			1	2	1		608
27075	090	40	3	20	240	30			2	3		1			1	2	1		633
27076	090	40	20	20	360	40			3	4		1			1	2	1		840
27077	090	40	20	20	400	45			4	4		1			1	2	1		905
27078	090	40	20	20	240	45			2	3		1			1	2	1		665
27327	090	14	8	10	30	20						0.5			1	1			140
27328	090	33	20	15	60	20			1			1			2	1			261
27329	090	40	20	20	120	30			1	1		1			1	3			413
27337	090	33	10	15	45	20						0.5			1	1			181
27339	090	40	20	20	90	20			1			1			1	2			310
27364	090	40	20	20	180	30			2	2		1			1	2	1		550
27365	090	40	3	20	240	30			2	3		1			1	2	1		633
27615	090	40	23	20	120	30			1	1		1			1	3			416
27616	090	40	23	20	150	30			1	1		1			1	2	1		463
27618	090	14	10	10	30	15						0.5			1	1			137
27619	090	33	23	15	60	20						0.5			2	1			225
27632	090	33	12	15	45	20						0.5			1	1			183
27634	090	33	23	15	70	20			1			1			1	2			281
27645	090	40	3	20	200	30			2	2		1			1	2	1		553
27646	090	40	20	20	180	40			1	2		1			1	2	1		540
27647	090	43	20	15	144	30			1	2		1			1	1	1		469
28039	090	19	6	5	45	20						0.5			1	1			153
28041	090	33	8	15	60	20						0.5			1	2			217
28043	090	19	6	5	30	20						0.5			1	1			138
28045	090	19	6	5	45	20						0.5			2	1			169
28046	090	33	8	15	90	25			2			1			1	3			334
28047	090	40	8	20	120	25			1	1		1			1	2	1		413
28120	090	33	10	15	50	20			1			1			3	2			280
28122	092	33	10	15	50	20			1			1			2	2			264
28171	090	43	20	15	120	30			1			1			1	1	1		365
28173	090	19	3	5	110	30			1			1			1	1	1		304
28175	090	19	3	5	60	20						0.5			1	1	1		205
28725	090	45	10	15	90	20			1			1			2	3			339
28730	090	45	10	15	100	20			1			1			2	3			349
29581	000	7			15	5													27
31626	000	19	1	5	45	15													85
31627	ZZZ				60														60
32552	010	13	1	6	15	12						0.5			1				82
32553	000	19	1	5	45	20													90
32560	000	18	1	6	20	20													65
32561	000	13	1	6	15	10													45
32562	000	13	1	6	10	10													40
33782	090	40	3	20	300	60	2		1	1	3	1					1		866
33783	090	40	3	20	360	60	2		1	1	3	1					1		926
36147	XXX	20			45	15													80
36148	ZZZ				15														15
36825	090	40	10	20	120	30			1			1			1	2			340
37761	090	33	10	15	60	25						0.5			1	2			224
42415	090	40	12	20	150	20						1			1	2			342
42420	090	40	12	20	180	20			1	1		1			1	2			432
43273	ZZZ				45														45
43281	090	40	15	15	180	30			1	1		1				2			424
43282	090	40	15	15	210	30			1	1		1				2			454
43775	090	40	25	20	120	30			1	1		1			1	1	1		412
45171	090	33	15	15	45	20						0.5			1	2			209
45172	090	40	15	20	75	20			1			1			1	2			290
46707	090	33	10	15	40	15						0.5			2	1			187

Physician Time for RUC Recommendations for CPT Cycle 2010

CPT Code	Global Period	Pre-Service Evaluation	Pre Service Positioning	Pre Service Srub Dress and Wait	Intra Service	Immediate Post	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
49411	000	19	1	5	40	20													85
49507	090	40	3	20	70	30			1			1			1	1			260
49521	090	40	3	20	90	30			1			1			1	1			280
49587	090	40	3	20	60	30			1			1			1	1			250
51727	000	20			35	10													65
51728	000	20			35	10													65
51729	000	20			40	15													75
53855	000	7			15	10													32
55873	090	33	8	15	100	30						0.5				3			274
57426	090	40	3	20	110	40				1		1				3			360
63655	090	33	15	15	90	20						1			1	2			273
63661	010	33	10	5	55	20						0.5				1			165
63662	090	33	15	15	60	20						1			1	2			243
63663	010	33	10	5	90	20						0.5				1			200
63664	090	33	15	15	90	20						1			1	2			273
64490	000	7	5	5	15	10													42
64491	ZZZ				15														15
64492	ZZZ				15														15
64493	000	7	5	5	15	10													42
64494	ZZZ				15														15
64495	ZZZ				15														15
69100	000	7			12	5													24
74261	XXX	5			40	5													50
74262	XXX	5			45	7													57
74263	XXX	7			38	5													50
75565	ZZZ				10														10
75571	XXX	5			10	5													20
75572	XXX	10			20	10													40
75573	XXX	15			30	15													60
75574	XXX	10			30	10													50
75791	XXX	15			25	15													55
76536	XXX	4			10	4													18
77338	XXX				115														115
78451	XXX	10			15	10													35
78452	XXX	10			20	10													40
78453	XXX	5			10	5													20
78454	XXX	5			15	5													25
88387	XXX				20														20
88388	ZZZ				12														12
90960	XXX				128														128
90961	XXX				113														113
92526	XXX	5			45	5													55
92540	XXX	7			60	10													77
92550	XXX	3			10	3													16
92570	XXX	3			15	3													21
92597	XXX	7			40	13													60
92610	XXX	7			35	10													52
92611	XXX	7			30	10													47
93750	XXX				30														30
94011	XXX	30			30	20													80
94012	XXX	30			60	25													115
94013	XXX				12.5	5													17.5
95905	XXX				5														5
96570	ZZZ				30														30
96571	ZZZ				15														15

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY						NON-FAC	
		1A	1B*	2A	2B*	3	4	5	6
	Total Pre-Service Time	**20**	**25**	**25**	**39**	**51**	**63**	**7**	**23**
	CATEGORY SUBTOTALS								
A	Pre-Service Evaluation (IWPUT =0.0224)	13	19	18	33	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	5	6	5	15	20	0	5
	DETAILS								
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	5	10	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	3	5	5	5	2	3
A	Communicate with other professionals	0	1	0	3	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	1	1	0	0
A	Administer moderate sedation/observe (wait) anesthesia care	0	5	0	10	0	0	0	0
B	Perform/ supervise patient positioning	1	1	1	1	3	3	0	1
C	Administer local anesthesia	1	0	1	0	0	0	0	5
C	Observe (wait anesthesia care)	0	0	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	5	5	0	0

* Indicates packages that contain moderate sedation

1A Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)
1B* Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)
2A Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)
2B* Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)
3 Straightforward Patient/Difficult Procedure
4 Difficult Patient/Difficult Procedure
5 Procedure without sedation/anesthesia care
6 Procedure with sedation/anesthesia care

Notes:

*Roll-over cells for additional detail where available

*Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice

*For building block IWPUT purposes whenever the procedure is on Appendix G – (Summary of CPT codes that include moderate (conscious) sedation) the IWPUT should be .0224 for the administration of moderate sedation line item because the physician is responsible for the administration of conscious sedation. If the procedure is one where conscious sedation is not inherent the same line item should have an IWPUT of .0081.

*Additional time may be justified for a straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support additional pre-service time.

PLI Crosswalk Codes for RUC Recommendations
CPT 2010

CPT Code	Modifier	PLI Crosswalk Code	Key Reference Code Yes/No	Surgical/ NonSurgical
14301		14300	No	Surgical
14302		49568	Yes	Surgical
21011		11642	Yes	Surgical
21012		11643	Yes	Surgical
21013		38510	Yes	Surgical
21014		38510	Yes	Surgical
21015		38700	Yes	Surgical
21016		41130	Yes	Surgical
21552		38510	Yes	Surgical
21554		38700	Yes	Surgical
21555		11642	Yes	Surgical
21556		38510	Yes	Surgical
21557		38700	Yes	Surgical
21558		15734	Yes	Surgical
21930		11606	Yes	Surgical
21931		38525	Yes	Surgical
21932		15100	Yes	Surgical
21933		38745	Yes	Surgical
21935		27880	Yes	Surgical
21936		49203	Yes	Surgical
22900		49505	Yes	Surgical
22901		49560	Yes	Surgical
22902		49580	Yes	Surgical
22903		38525	Yes	Surgical
22904		49203	Yes	Surgical
22905		49203	Yes	Surgical
23071		20680	Yes	Surgical
23073		29828	Yes	Surgical
23075		11406	Yes	Surgical
23076		13132	Yes	Surgical
23077		23077	No	Surgical
23078		23472	Yes	Surgical
23200		27447	Yes	Surgical
23210		27134	Yes	Surgical
23220		27134	Yes	Surgical
24071		20680	Yes	Surgical
24073		25115	Yes	Surgical
24075		11406	Yes	Surgical
24076		25109	Yes	Surgical
24077		23395	Yes	Surgical
24079		24363	Yes	Surgical
24150		24363	Yes	Surgical
24152		24363	Yes	Surgical
25071		20680	Yes	Surgical
25073		26545	Yes	Surgical
25075		11406	Yes	Surgical
25076		25109	Yes	Surgical
25077		25515	Yes	Surgical
25078		25025	Yes	Surgical
25170		24363	Yes	Surgical
26111		20680	Yes	Surgical
26113		25109	Yes	Surgical
26115		26115	Yes	Surgical
26116		25109	Yes	Surgical

PLI Crosswalk Codes for RUC Recommendations
CPT 2010

CPT Code	Modifier	PLI Crosswalk Code	Key Reference Code Yes/No	Surgical/ NonSurgical
26117		25447	Yes	Surgical
26118		29807	Yes	Surgical
26250		25447	Yes	Surgical
26260		25447	Yes	Surgical
26262		24685	Yes	Surgical
26480		26480	No	Surgical
27043		38525	Yes	Surgical
27045		47100	Yes	Surgical
27047		46040	Yes	Surgical
27048		15100	Yes	Surgical
27049		47380	Yes	Surgical
27059		27134	Yes	Surgical
27075		27134	Yes	Surgical
27076		20956	Yes	Surgical
27077		20956	Yes	Surgical
27078		27134	Yes	Surgical
27327		11622	Yes	Surgical
27328		15100	Yes	Surgical
27329		27329	Yes	Surgical
27337		20680	Yes	Surgical
27339		27880	Yes	Surgical
27364		27447	Yes	Surgical
27365		27134	Yes	Surgical
27615		27880	Yes	Surgical
27616		27447	Yes	Surgical
27618		11406	Yes	Surgical
27619		25109	Yes	Surgical
27632		20680	Yes	Surgical
27634		28299	Yes	Surgical
27645		27156	Yes	Surgical
27646		27447	Yes	Surgical
27647		27580	Yes	Surgical
28039		28525	Yes	Surgical
28041		29891	Yes	Surgical
28043		28043	Yes	Surgical
28045		13121	Yes	Surgical
28046		28299	Yes	Surgical
28047		27447	Yes	Surgical
28120		28289	Yes	Surgical
28122		28122	No	Surgical
28171		27580	Yes	Surgical
28173		28715	Yes	Surgical
28175		29891	Yes	Surgical
28725		28725	No	Surgical
28730		28730	No	Surgical
29581		29580	Yes	Surgical
31626		31629	Yes	Surgical
31627		31637	Yes	Surgical
32552		36589	Yes	Surgical
32555		31628	No	Surgical
32560		32421	No	Surgical
32561		94003	No	Surgical
32562		96570	No	Surgical
33782		33413	Yes	Surgical

PLI Crosswalk Codes for RUC Recommendations
CPT 2010

CPT Code	Modifier	PLI Crosswalk Code	Key Reference Code Yes/No	Surgical/ NonSurgical
33783		33980	No	Surgical
36147		19103	No	Surgical
36148		36620	No	Surgical
36825		36819	Yes	Surgical
37761		37500	Yes	Surgical
42415		42415	No	Surgical
42420		42420	No	Surgical
43273		43235	Yes	Surgical
43281		44204	No	Surgical
43282		43644	Yes	Surgical
43775		43279	No	Surgical
45171		45190	Yes	Surgical
45172		45170	No	Surgical
46707		46280	Yes	Surgical
49411		48102	Yes	Surgical
49507		49507	No	Surgical
49521		49521	No	Surgical
49587		49587	No	Surgical
51727		54231	No	Surgical
51728		54231	No	Surgical
51729		55700	No	Surgical
53855		53620	Yes	Surgical
55873		55875	Yes	Surgical
57426		57296	Yes	Surgical
63655		63655	No	Surgical
63661		62355	Yes	Surgical
63662		63030	Yes	Surgical
63663		63650	Yes	Surgical
63664		62351	Yes	Surgical
64490		62310	Yes	Surgical
64491		64627	Yes	Surgical
64492		64627	Yes	Surgical
64493		27096	Yes	Surgical
64494		20526	Yes	Surgical
64495		64623	Yes	Surgical
69100		11100	Yes	Surgical
74261		75635	Yes	Non-Surgical
74261	26	75635	Yes	Non-Surgical
74261	TC	0 PLI		
74262		75635	Yes	Non-Surgical
74262	26	75635	Yes	Non-Surgical
74262	TC	0 PLI		
74263		75635	Yes	Non-Surgical
74263	26	75635	Yes	Non-Surgical
74263	TC	0 PLI		
75565		93320	Yes	Non-Surgical
75565	26	93320	Yes	Non-Surgical
75565	TC	0 PLI		
75571		77003	No	Non-Surgical
75571	26	77003	No	Non-Surgical
75571	TC	0 PLI		
75572		70498	No	Non-Surgical
75572	26	70498	No	Non-Surgical
75572	TC	0 PLI		

PLI Crosswalk Codes for RUC Recommendations CPT 2010

CPT Code	Modifier	PLI Crosswalk Code	Key Reference Code Yes/No	Surgical/ NonSurgical
75573		75558	No	Non-Surgical
75573	26	75558	No	Non-Surgical
75573	TC	0 PLI		
75574		75557	No	Non-Surgical
75574	26	75557	No	Non-Surgical
75574	TC	0 PLI		
75791		75662	No	Non-Surgical
75791	26	75662	No	Non-Surgical
75791	TC	0 PLI		
76536		76776	No	Non-Surgical
76536	26	76776	No	Non-Surgical
76536	TC	0 PLI		
77338		77295	No	Non-Surgical
77338	26	77295	No	Non-Surgical
77338	TC	0 PLI		
78451		78464	No	Non-Surgical
78451	26	78464	No	Non-Surgical
78451	TC	0 PLI		
78452		78465	No	Non-Surgical
78452	26	78465	No	Non-Surgical
78452	TC	0 PLI		
78453		78460	No	Non-Surgical
78453	26	78460	No	Non-Surgical
78453	TC	0 PLI		
78454		78461	No	Non-Surgical
78454	26	78461	No	Non-Surgical
78454	TC	0 PLI		
88387		88329	No	Non-Surgical
88387	26	88329	No	Non-Surgical
88387	TC	0 PLI		
88388		88318	No	Non-Surgical
88388	26	88318	No	Non-Surgical
88388	TC	0 PLI		
92526		92557	No	Non-Surgical
92540		92620	No	Non-Surgical
92550		92621	No	Non-Surgical
92570		92557	No	Non-Surgical
92597		99214	No	Non-Surgical
92610		92604	Yes	Non-Surgical
92611		92557	No	Non-Surgical
93750		93289	No	Non-Surgical
94011		99480	No	Non-Surgical
94012		99480	No	Non-Surgical
94013		94070	No	Non-Surgical
95905		76977	No	Non-Surgical
96570		96570	No	Non-Surgical
96571		96571	No	Non-Surgical

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct-08	Destruction of Skin Lesions	11	CPT 2009	September 2013
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct-08	Destruction of Skin Lesions	11	CPT 2009	September 2013
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct-08	Destruction of Skin Lesions	11	CPT 2009	September 2013
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr-06	Fibroadenoma Cryoablation	11	CPT 2007	September 2010
20696	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment, assessment, and computation of adjustment schedule	Apr-08	Computer Dependent External Fixation	6	CPT 2009	September 2012
20697	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr-08	Computer Dependent External Fixation	6	CPT 2009	September 2012
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr-06	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels	Apr-06	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdisection), single interspace, cervical	Apr-08	Cervical Arthroplasty	7	CPT 2009	September 2012
22857	Total disc arthroplasty (artificial disc), including anterior approach, including diskectomy to prepare interspace (other than for decompression), lumbar, single interspace	Feb-06	Lumbar Arthroplasty	8	CPT 2007	September 2010
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical	Apr-08	Cervical Arthroplasty	7	CPT 2009	September 2012
22862	Revision including replacement of total disc arthroplasty (artificial disc) including anterior approach, lumbar, single interspace (includes approach)	Feb-06	Lumbar Arthroplasty	8	CPT 2007	September 2010
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical	Apr-08	Cervical Arthroplasty	7	CPT 2009	September 2012
22865	Removal of total disc arthroplasty (artificial disc), including anterior approach, lumbar, single interspace	Feb-06	Lumbar Arthroplasty	8	CPT 2007	September 2010
29828	Tenodesis of long tendon of biceps	Apr-07	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed;with placement of fiducial markers, single or multiple	Apr-09	Fiducial Marker Placement	6	CPT 2010	September 2013
31627	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with computer-assisted, image-guided navigation	Feb-09	Navigational Bronchoscopy	9	CPT 2010	September 2013
32998	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleur or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	Apr-06	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr-06	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2010
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2010
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr-06	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2010

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2007	September 2010
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	CPT 2007	September 2010
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	CPT 2008	September 2011
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	CPT 2008	September 2011
43273	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)	Apr-08	Cholangioscopy-Pancreatoscopy	13	CPT 2009	September 2012
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr-08	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr-09	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013 *Review volume*

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr-09	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013 *Review volume*
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr-06	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010
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	CPT 2007	September 2010
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr-09	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr-06	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr-09	Fistula Plug	15	CPT 2010	September 2013
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr-07	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb-09	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013
55706	Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance	Apr-08	Saturation Biopsies	15	CPT 2009	September 2012
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr-07	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct-08	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013
57426	Revision (including removal) of prosthetic vaginal graft; laparoscopic approach	Oct-08	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2010
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	CPT 2007	September 2010

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;	Feb-06	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2010
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	CPT 2007	September 2010
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr-07	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2011
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	CPT 2008	September 2011
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 gram	Apr-07	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2011
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	CPT 2008	September 2011
63620	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion	Apr-08	Stereotactic Radiosurgery	16	CPT 2009	September 2012
63621	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr-08	Stereotactic Radiosurgery	16	CPT 2009	September 2012
65756	Keratoplasty (corneal transplant); endothelial	Apr-08	Endothelial Keratoplasty	20	CPT 2009	September 2012
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure) (Use 65757 in conjunction with 65756)	Apr-08	Endothelial Keratoplasty	20	CPT 2009	September 2012
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr-07	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011
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	CPT 2007	September 2010
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb-06	Functional MRI	15	CPT 2007	September 2010
74261	Computed tomographic (CT), colonography, diagnostic, including image postprocessing; without contrast material	Apr-09	CT Colonography	19	CPT 2010	September 2013

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
74262	Computed tomographic (CT), colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr-09	CT Colonography	19	CPT 2010	September 2013
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr-09	CT Colonography	19	CPT 2010	September 2013
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr-07	Cardiac MRI	F	CPT 2008	September 2011
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification	Apr-07	Cardiac MRI	F	CPT 2008	September 2011
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr-07	Cardiac MRI	F	CPT 2008	September 2011
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	Apr-07	Cardiac MRI	F	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
75571	Computed tomography, heart without contrast material, with quantitative evaluation of coronary calcium	Feb-09	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb-09	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Feb-09	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb-09	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013
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	CPT 2007	September 2010
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	CPT 2007	September 2010
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	CPT 2007	September 2010
77435	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	Apr-06	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr-07	PET Imaging	G	CPT 2008	September 2011
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr-07	PET Imaging	G	CPT 2008	September 2011
78813	Positron emission tomography (PET) imaging; whole body	Apr-07	PET Imaging	G	CPT 2008	September 2011

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb-07	Manual Microdisection	12	CPT 2008	September 2011
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb-07	Manual Microdisection	12	CPT 2008	September 2011
88384	Array-based evaluation of multiple molecular probes; 11 through 50 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010
88385	Array-based evaluation of multiple molecular probes; 51 through 250 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010
88386	Array-based evaluation of multiple molecular probes; 251 through 500 probes	Apr-05	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010
88387	Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)	Apr-09	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013
88388	Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr-09	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
93228	Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93229	Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93279	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead pacemaker system (Do not report 93279 in conjunction with 93286 or 93288)	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93280	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
93281	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93282	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93283	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93284	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93285	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; implantable loop recorder system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93286	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93287	Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead implantable cardioverter defibrillator system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93288	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
93289	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead implantable cardioverter defibrillator system, including analysis of heart rhythm derived data elements	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93290	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm data derived analysis	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93292	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with report(s) up to 90 days	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s)	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s); single, dual, or multiple lead pacemaker system or implantable cardioverter defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s); implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr-08	Cardiac Device Monitoring	23	CPT 2009	September 2012
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	CPT 2008	September 2011
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr-09	Infant Pulmonary Function Testing	23	CPT 2010	September 2013
94012	Measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age	Apr-09	Infant Pulmonary Function Testing	23	CPT 2010	September 2013
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [VVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr-09	Infant Pulmonary Function Testing	23	CPT 2010	September 2013

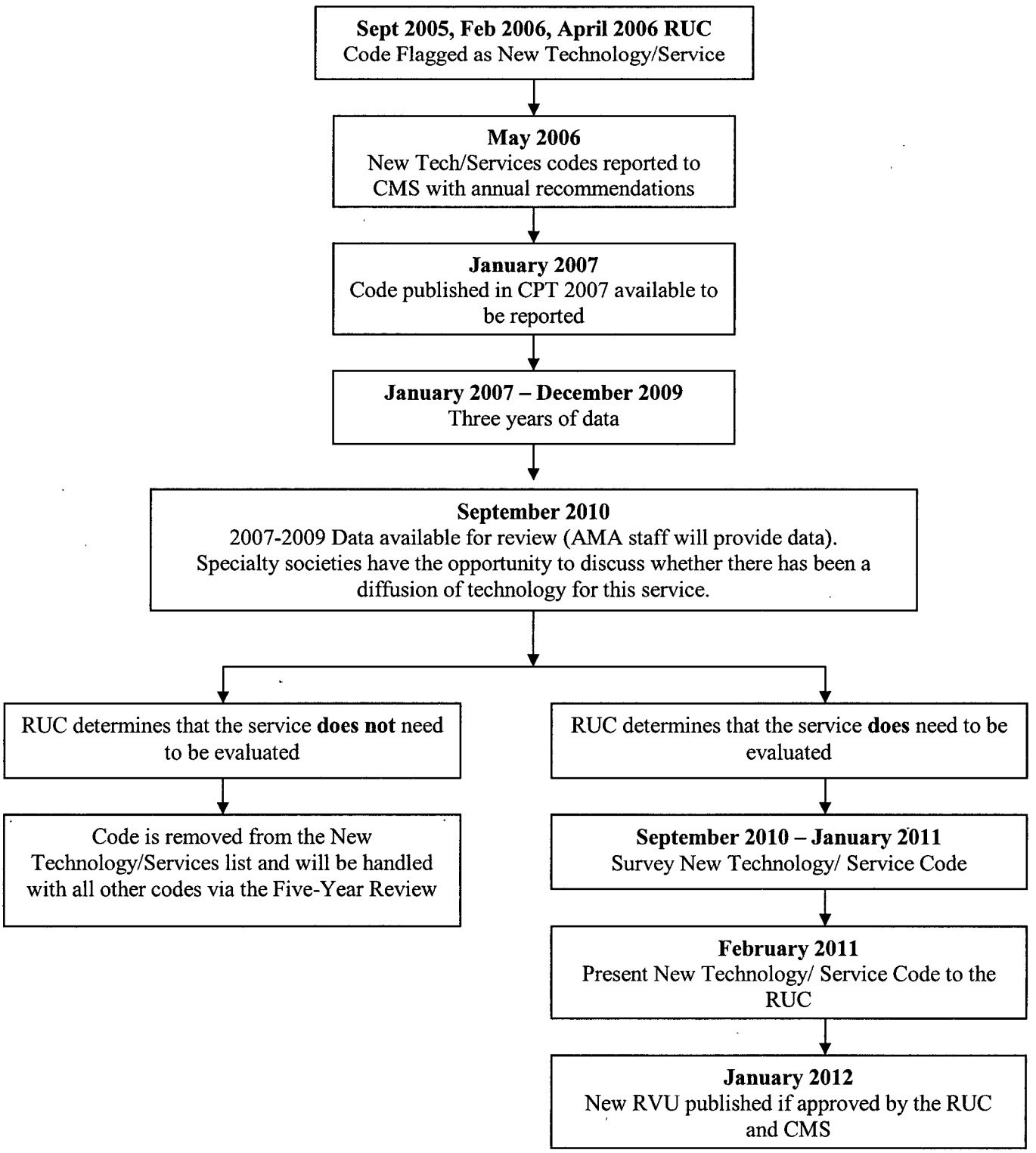
CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
95803	Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording)	Apr-08	Actigraphy Sleep Assessment	25	CPT 2009	September 2012
95905	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study,	Feb-09	Nerve Conduction Tests	18	CPT 2010	September 2013
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of	Apr-07	Electronic Analysis of Implanted Neurostimulator	I	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2008	September 2011
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	CPT 2007	September 2010
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	CPT 2007	September 2010

CPT Code	Descriptor	Meeting	Issue	Tab	CPT Year	Date to be Re-reviewed
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	CPT 2007	September 2010
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	CPT 2007	September 2010
99441	Telephone Evaluation and Management, 5-10 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	CPT 2008	September 2011
99442	Telephone Evaluation and Management, 11-20 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	CPT 2008	September 2011
99443	Telephone Evaluation and Management, 21-30 minutes of medical discussion	Feb-07	Non Face-to-Face Services	16	CPT 2008	September 2011

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Multi-Layer Compression System Application

In February 2009, the CPT Editorial Panel created a new code to describe treatment of chronic venous insufficiency with ulceration with multi-layer compression strapping systems.

The RUC reviewed the specialty society survey data for code 29581 *Application of multi-layer venous wound compression system, below knee* and compared it to reference code 29580 *Unna boot* (work RVU = 0.55, 8 minutes pre-service time, 12 minutes intra-service time and 7 minutes immediate post-service time). The RUC determined that 29581, application of a multi-layer compression system is more intense and complex and requires more time to apply than 29580, a single layer zinc-oxide ointment containing strapping system. The multi-layer systems come with very specific instructions for use and the various layers must be applied in a bias pattern with respect to one another. The specialty society indicated and the RUC agreed that pre-service package 5 – Non-Facility procedure without sedation/anesthesia (7 minutes) is appropriate, reflecting that the typical patient requires more complex dressings, has a larger ulcer and advanced surrounding venous skin. The survey respondents indicated an intra-service time of 15 minutes, 3 minutes more than 29580, which the specialty society and RUC agreed was appropriate to apply this multi-layer system. Additionally, the RUC agreed with the specialty society recommended immediate post-service time of 5 minutes, noting that the survey respondents indicated that this is lower than 29580 by 2 minutes even though a thorough neurovascular evaluation must be performed after application of this tight multi-layer system.

The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 0.60 appropriately accounted for the physician work and time required to perform 29581 and placed this service in the proper rank order. The RUC also compared 29581 to a slightly more intense MPC reference code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (work RVU = 0.61) to further support this work RVU. **The RUC recommends the survey 25th percentile, 0.60 work RVU for 29581.**

Practice Expense

The RUC reviewed the practice expense and made minor edits to the medical supplies for code 29581.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
29540		Strapping; ankle and/or foot (Do not report 29540 in conjunction with 29581)	000	0.51 (No Change)
•29581	S1	Application of multi-layer venous wound compression system, below knee (Do not report 29581 in conjunction with 29540, 29580)	000	0.60
29580		Unna boot (Do not report 29580 in conjunction with 29581)	000	0.55 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29581 Tracking Number S1 Specialty Society Recommended RVU: **0.60**

Global Period: 000 RUC Recommended RVU: **0.60**

CPT Descriptor: Application of multi-layer venous wound compression system, below knee

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman returns to the office for treatment of a medial calf ulcer. It measures 3x3 cm and demonstrates no signs of infection. She has palpable pedal pulses. Pigmented skin changes in the gaiter distribution of both lower extremities are consistent with chronic venous insufficiency. The wound is examined, cleansed and a multilayer venous ulcer compression dressing is applied.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

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

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

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

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

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

Description of Pre-Service Work: An abbreviated history is obtained. All prior dressings are removed, taking care to avoid injuring the underlying skin. Physical exam is performed which assesses adequate arterial flow, the presence of infection, the degree of swelling, and the size/depth of the lower extremity ulcer. Treatment options are reviewed and communication occurs with the patient (and/or the patient's family) to explain the procedure, including a discussion of possible risks and complications.

Description of Intra-Service Work: The ulcer is cleansed, and a primary wound dressing is then applied. With the foot in a dorsiflexed position, application of the compression bandage is initiated with a circular winding at the base of the toes. The second circular winding follows and covers the top of the foot and articulating aspect of the ankle joint. The next winding is applied and covers the back of the heel and the calf. Frequent checks are performed to ensure the foot is in a neutral position relative to the ankle. Each subsequent application is applied at the specific stretch needed for the desired compression.

Description of Post-Service Work: The patient's neurovascular status is evaluated after the dressing system has been completely applied and is allowed to "set" for a few minutes. A surgical shoe is fitted on the patient. Instructions are provided for care and activity. Progress note and any correspondence with referring physicians are completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Frank Spinosa DPM, Gary Seabrook MD FACS, Matthew Sideman MD FACS, David Han MD FACS, Christopher Senkowski MD FACS, Eric VanDoorne				
Specialty(s):	APMA, SVS, ACS, APTA				
CPT Code:	29581				
Sample Size:	300	**Resp N:**	72	**Response:** 24.0 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**20.00**	100.00	1000.00
Survey RVW:	0.40	0.60	**0.76**	1.01	2.00
Pre-Service Evaluation Time:			**16.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	30.00

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

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

Specialty Society Recommended Data

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

CPT Code:	29581	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

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

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
29580	000	0.55	**RUC Time**

CPT Descriptor Strapping; Unna boot

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11056	000	0.61	**RUC Time**	1,404,799

CPT Descriptor 1 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29075	000	0.77	**RUC Time**	69,576

CPT Descriptor 2 Application, cast; elbow to finger (short arm)

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:** 56.9 %

TIME ESTIMATES (Median)	**CPT Code: 29581**	**Key Reference CPT Code:** 29580	**Source of Time** RUC Time
Median Pre-Service Time	7.00	8.00	
Median Intra-Service Time	15.00	12.00	
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	**27.00**	**27.00**	
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	3.05	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.05	2.93
Urgency of medical decision making	2.54	2.51

Technical Skill/Physical Effort (Mean)

Technical skill required	3.10	2.90
Physical effort required	2.76	2.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.76	2.63
Outcome depends on the skill and judgment of physician	3.24	3.10
Estimated risk of malpractice suit with poor outcome	2.73	2.68

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.56	2.59
Intra-Service intensity/complexity	3.05	2.88
Post-Service intensity/complexity	2.00	2.10

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.*

RATIONALE

Clinical Overview: Maintenance therapy for chronic venous insufficiency in patients without ulceration is usually accomplished with medical-grade graduated compression stockings. However, the mainstay of therapy in treating chronic venous insufficiency with ulceration is compression strapping systems. The Unna boot (29580) is a single layer

zinc-oxide ointment containing strapping system. New code 29581 describes a newer multi-layer compression device that has been demonstrated in numerous scientific analyses, including a Cochrane review, to provide faster and superior wound healing. The multi-layer systems are more sophisticated than the single layer Unna boot and require more time and more attention to detail to apply correctly.

RVW Recommendation: The multi-specialty consensus committee recommends **the survey 25th percentile work RVU or 0.60** which is slightly greater than key reference code 29850. This value reflects the incremental time and complexity of the multi-layer system compared with the key reference, Unna boot.

Pre-Time Considerations: We recommend package 5 (non-facility procedure without sedation/anesthesia care)

- Evaluation: no change (7 min)

It should be noted that this is a very substantial reduction from the actual survey Pre-Service time of 26.

Work Comparison to key reference code: 29850 Unna boot

New code 2985X Application of multi-layer venous wound compression system is more complex and more time consuming than application of an Unna boot. The multi-layer systems come with very specific Instructions for Use, and the various layers must be applied in a bias pattern with respect to one another. This additional work is reflected in the survey data by an additional 3 minutes of intra-service time. Also, 9 of the 11 intensity and complexity measures are greater for 2958X than 29580, confirming that the intra-work is slightly more complex.

Pre-service time is 2 minutes longer for 2958X than 29580, reflecting the fact that the typical patient requiring this more complex dressing has a larger ulcer and more advanced surrounding venous skin changes than the typical 29580 patient. Removing the prior dressing and cleansing the wound and adjacent limb take longer and requires more attention. It should be noted that the actual survey Pre-Service time was 26 minutes, and our Expert Panel reduced that value to 10 minutes to be in keeping with package 5 and to be more appropriately related to the key reference service pre-time of 8 minutes.

Immediate post-service time in the survey median value is 5 minutes. This is actually 2 minutes less than post-service time of 29580 Unna boot. A thorough neurovascular evaluation must be performed after application of this tight, strong, multi-layer dressing. It doesn't make any clinical sense that the post-time would be 2 minutes less than the reference service, but we decided not to change it.

Given all these considerations, including 3 additional minutes of total time over the key reference, we believe that the recommended RVW of 0.60 is appropriately valued when compared to the 0.55 RVW of the key reference.

Work Comparison to MPC List Code: 11056 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

11056 is a RUC-surveyed MPC list service valued at 0.61. It has 8 minutes of intra-service time and 15 minutes total time. 11056 is commonly performed by podiatrists, as will be the new code 29581. The new code has twice the intra-time (15 compared to 8 minutes) and twice the total time (30 compared to 15 minutes), while the reference code is slightly more intense. By this comparison, a recommended RVW of 0.60 is appropriate, perhaps conservative.

Work Comparison to Another MPC List Code: 29075 Application of short arm cast.

29075 is application of a short arm cast, typically performed for a fracture, while 29581 will be performed on the lower extremity for an ulcer. 29075 is a RUC surveyed service (2005) with Intra-time of 15 minutes and total time of 25 minutes. 29581 has the same intra time (15 minutes) and 5 more minutes total time (30 compared to 25 minutes). 29075 has somewhat greater complexity because the fractured limb must be maintained in alignment while the cast is applied. Both services require a thorough neurovascular check during post-service, and both require instructions be given to the

patient. 29075 has an RVW of 0.77. Given the similarities noted here, we believe an RVW of 0.60 for the new service ranks it appropriately with respect to this MPC reference.

IWPUT

IWPUT for short and low intensity services does not seem to have the discriminative value that it does for large 90-day global services, but at the recommended RVW and time values, the IWPUT of this service is 0.020, which is the same as the key reference service. At very least, this indicates that our recommendation of 0.60 is not over-valued when considered with respect to the time involved.

SERVICES REPORTED WITH MULTIPLE 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) When a patient undergoes initial evaluation of a leg ulcer, a consultation E&M code will be appropriately reported because there is a wide differential diagnosis for skin wounds and ulcers. The patient will need all elements of History, ROS, PMH, FHSH, Meds, Allergies, full physical exam, diagnostic study evaluation and significant medical decision making. However, once the diagnosis of venous ulcer is established and the course of wound care prescribed, the patient undergoing multi-layer dressing will not need a coincident E&M service during a typical visit. ONLY the 2958X code will be reported. This pattern is analogous to the 29580 Unna boot code, wherein Todd Klemp of AMA RUC determined that 70% of 29580 services are reported WITHOUT a coincident E&M.

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. As noted above, typical scenario for multiple codes will be first time evaluation of patient with leg ulcer. In this case a level 2 or level 3 outpatient consultation is likely to be co-reported. Subsequently, an established patient office visit would be reportable ONLY if the patient has suffered a significant deterioration in status such that a full reconsideration of his/her status must be undertaken. In that situation, appropriate documentation would be required to justify co-reporting of 29581 and the established patient visit. As noted above, Mr. Klemp determined that only 30% of the parent code 29580 are reported with an E&M service (therefore 70% without E&M).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) We believe the majority of these services have been reported as 29580. However, one of the ma. reasons for requesting this code is fact that several carriers deny payment for 29580 when a multilayer dressing is used instead of an Unna boot. It is impossible to determine how large this component is, and whether providers who are routinely denied payment for this reason are submitting (or resubmitting) using an unlisted service code.

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

Specialty Podiatry How often? Commonly

Specialty Vascular Surgery 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? 300000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We have no way of accurately predicting the utilization of this new CPT code, however, the number will not be trivial. It has been estimated that 2.5 million patients have venous ulcers in the US, but it is not known how many of those patients seek professional medical advice for the problem. CPT 29580, the single layer Unna boot is reported almost 450,000 times to Medicare per year, and since venous ulcers occur commonly in individuals younger than Medicare age, we could estimate the overall frequency may be twice Medicare, perhaps as many as 900,000 per year. Some proportion of these will be switched from 29580 to the new code. Also, we don't have estimates of how many multi-layer dressings are reported as unlisted service to Carriers who deny 29580 for this purpose. Podiatrists are the dominant provider of 29580 Unna boot, which is the only current CPT code used to report an analogous product. We believe the new service will be provided along similar specialty proportionality lines: Podiatry 36%, General Surgery 20%, Vascular Surgery 10%, Family Practice 7%, Derm 7%, Nurse Practitioner 5%, Internal Medicine 4%, PA 2%, PT 2%

Specialty Podiatry	Frequency 180000	Percentage 60.00 %
Specialty General Surg	Frequency 60000	Percentage 20.00 %
pecialty Vasc Surg	Frequency 30000	Percentage 10.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The assumption here is that one-third of dressings currently reported as 29580 will be switched to 29581, and another contribution to frequency will derive from providers who currently use an unlisted code for this service. The latter is impossible to predict, so we chose one-third of the 29580 frequency.

Specialty Podiatry	Frequency 90000	Percentage 60.00 %
Specialty Gen Surg	Frequency 30000	Percentage 20.00 %
Specialty Vasc Surg	Frequency 15000	Percentage 10.00 %

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 Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor:

S1	29581	Application of multi-layer venous wound compression system, below knee

Sample Size N/A

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

The direct non-facility practice expense details were discussed by a consensus committee of podiatrists, vascular surgeons, general surgeons, and physical therapists representing a variety of practice types and geographic settings.

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

Clinical staff will respond to phone call(s) from patient/family/caregiver regarding dressing protection/care and activities (eg, bathing, leg elevation).

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

CPT Long Descriptor:

S1	29581	Application of multi-layer venous wound compression system, below knee

Sample Size N/A

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

The direct non-facility practice expense details were discussed by a consensus committee of podiatrists, vascular surgeons, general surgeons, and physical therapists representing a variety of practice types and geographic settings.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

The procedure room is prepared, making certain supplies and equipment necessary are available. Clinical staff reviews the chart to be certain all pre-procedure information is available and the H&P is current. The patient will be greeted and gowned. The procedure is reviewed with the patient/family. The prior dressing is removed. Clinical staff assists the physician with cleansing the wound, preparing for the new dressing, and positioning the patient and leg. Clinical staff will assist physician 2/3 of total physician intra-time. After completion of the procedure, clinical staff will monitor the patient who needs to maintain position while dressing dries; clean the room; provide instructions on dressing protection/care and activities (eg, bathing, leg elevation); discuss follow-up visits; and assist the physician with surgical shoe placement and adjustment.

Post-Service Clinical Labor Activities

Clinical staff will respond to phone call(s) from patient/family/caregiver regarding dressing protection/care and activities (eg, bathing, leg elevation).

	A	B	C	D	E
1	**Meeting Date: April 2009**			**29581**	
2	**AMA/Specialty Society RVS Update Committee Recommendation**			**Application of multi-layer venous wound compression system, below knee**	
3	**LOCATION**	**Code**	**Staff Type**	**NonFac**	**FAC**
4	**GLOBAL PERIOD**			**000**	**000**
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**37**	**3**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**34**	**0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**3**	**3**
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	**0**	**0**
12	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**0**	**0**
13	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**0**
14	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**	**0**
15	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**0**	**0**
17	**End:When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters site for procedure: Services Prior to Procedure**				
20	Review charts	**L037D**	RN/LPN/MTA	**2**	
21	Greet patient and provide gowning	**L037D**	RN/LPN/MTA	**3**	
22	Obtain vital signs	**L037D**	RN/LPN/MTA		
23	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**1**	
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**	
25	Setup scope (non facility setting only)	**L037D**	RN/LPN/MTA		
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**	
27	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA		
28	**Intra-service**				
29	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**10**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA		
32	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**	
33	Clean Scope	**L037D**	RN/LPN/MTA		
34	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA		
35	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA		
36	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA		
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**4**	
38	Discharge day management	**L037D**	RN/LPN/MTA		
39	**Other Clinical Activity (please specify): Prior dressing removal at start of visit**	**L037D**	RN/LPN/MTA	**7**	
40	**End: Patient leaves office**				
41	**POST-SERVICE Period**				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions			**3**	**3**
52	***Total Office Visit Time***	**L037D**	RN/LPN/MTA	**0**	**0**
53	***Other Total:***				
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**	**Code**	**Unit**		
56	pack, minimum multi-specialty visit	**SA048**	**pack**	**1**	
57	underpad 2ft x 3ft (Chux)	**SB044**	**item**	**1**	
58	basin, irrigation	**SJ009**	**item**	**1**	
59	towel, non-sterile	**SB042**	**item**	**2**	
60	water, sterile for irrigation (250-1000ml uou)	**SH074**	**item**	**1**	
61	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**item**	**1**	
62	chlorhexidine topical cleanser (Hibiclens)	**NEW**	**ml**	**20**	
63	multi-layer venous ulcer dressing system	**NEW**	**kit**	**1**	
64	gown, staff, impervious	**SB027**	**item**	**1**	
65	**Equipment**	**Code**			
66	table, exam	**EF023**		**34**	**0**
67	light, exam	**EQ168**		**34**	**0**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
April 2009

Fiducial Marker Placement

Stereotactic radiosurgery (SRS) is now performed throughout the entire body as existing technology is being utilized in an array of different permutations with variable physician and clinician collaboration models. Currently, there are CPT codes for fiducial placement for the prostate, brain, and spine, however the FDA has approved SRS to be performed for lesions, tumors and conditions anywhere in the body. Current coding schemes do not accurately reflect the components, shared work, and reality that multiple clinicians contribute to the delivery of this complex services, and thoracic and abdominal SRS have become more common over the past several years for treatment of inoperable tumors. In February 2009, the CPT Editorial Panel developed two new codes to cover fiducial placement in the thorax and abdomen and one code to describe electromagnetic navigation bronchoscopy of the pulmonary tract for the purposes of placing radiosurgical markers for SRS or for the purposes of placing dye markers for surgical assistance in video-assisted thoracic surgery (VATS) procedures.

31626 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with placement of fiducial markers, single or multiple***
The RUC reviewed the specialty survey results from 38 pulmonologists. The survey respondents chose CPT code 31629 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (Work RVU = 4.09, 000 day global) as the key reference service. Code 31626 is typically performed in the facility setting and is considered straight forward requiring sedation/anesthesia care, much like its reference service. The survey respondents indicated a median physician work relative value slightly higher than the reference code, with similar physician complexities and intensities. The survey respondents indicated that the intra-service period is 15 minutes longer for 31626 than reference code 31629 because precision is required to inject dye markers into the soft lung tissue. The RUC agreed with the survey respondents median work relative value of 4.16 which provides for the proper work valuation and rank order for this new service in comparison to the reference code. **The RUC recommends a physician work relative value of 4.16 RVUs for new code 31626.** Moderate sedation is also required for this service and it will be displayed in appendix G for CPT 2010.

32553 ***Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple***
The RUC reviewed the specialty's survey results carefully and concurred that the appropriate pre-service time package for this service should reflect a straightforward patient and procedure with sedation/anesthesia care, pre-time package 1b. This change aligns the

physician time and work with similar services such as new code 31626 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with placement of fiducial markers, single or multiple* (recommended Work RVU = 4.16, 000 day global), however the RUC concurred that this new service requires less work to perform as it does not involve a bronchoscopy. The RUC also reviewed the specialties key reference service 32998 *Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral* (Work RVU = 5.68, 000 day global) in relation to new code 32553, and agreed 32998 required somewhat similar techniques; however, the service is much more complex, and intense, and required more physician time. 32998 was surveyed having 60 minutes of intra-service time whereas 32553 was indicated to have 45 minutes. In addition to the specialty's key reference service, the RUC reviewed another similar service 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (Work RVU = 3.80, 000 day global, 40 minutes intra-service time) and agreed the physician work value of new code 32553 should be aligned with 31628 as the surveyed physician time, intensities, and complexities were similar. Although a value of 3.80 RVUs is below the low of the specialty's surveyed RVW results the RUC agreed it is appropriate and preserves rank order amongst other similar services. **The RUC recommends a physician relative work value of 3.80 for CPT code 32553.** To support the relativity amongst services the committee also reviewed the work, time, and intensities of codes 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (Work RVU 4.17, 000 day global) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (Work RVU = 2.50, 000 day global).

49411 ***Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple***

The RUC reviewed the specialties survey results carefully and concurred that the appropriate pre-service time package for this service should reflect a straightforward patient and procedure with sedation/anesthesia care, pre-time package 1b. CPT code 49411 is slightly more complex when compared to new code 32553 as reflected in the median survey data which shows 5.70 Work RVUs 32553 and 6.00 work RVUs for 49411. The specialty societies explained and the RUC agreed that there is a greater degree of difficulty in placing fiducial markers in the abdomen because of the increased number of anatomic structures in the abdomen (ie. liver, spleen, stomach, bowel, pancreas) as compared to the anatomic structures in the thorax (ie, lungs) which makes 49411, as compared to 32553, more difficult to reach the tumor. It was also agreed that the greater difficulty posed by the increased number of structures outweighed the risk of pneumothorax in the chest. This 0.02 work RVU increment between 49411 and 32533 accurately reflects the difference in difficulty in performing the procedure The RUC also reviewed code 31630 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal/bronchial dilation or closed reduction of fracture* (work RVU = 3.81, 45 minutes intra-service time) in relation to the new code as well. After reviewing all of the survey data in its entirety, the RUC concurred that 49411 should be valued at 3.82 Work RVUs. **The RUC recommends a physician work relative value of 3.82 for CPT code 49411.**

New Technology
The RUC recommends that codes 31626, 32553, and 49411 be placed on the new technology list.

Direct Practice Expense Inputs
The practice expense direct inputs recommended by the specialty were reviewed carefully, edited slightly for appropriate clinical labor time, and approved for these services.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E ⊙31622		Bronchoscopy, rigid or flexible, including~~with or without~~ fluoroscopic guidance, when performed; diagnostic, with ~~or without~~ cell washing, when performed (separate procedure)	000	2.78 (No Change)
•⊙31626	T1	with placement of fiducial markers, single or multiple (Report supply of device separately) (Use 31626 in conjunction with 31615, 31627, 31623-31631, 31635, 31636, 31638-31643)	000	4.16
•⊙+31627		with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s]) (31627 includes 3D reconstruction. Do not report 31627 in conjunction with 76376, 76377) (Use 31627 in conjunction with 31615, 31626, 31622-31631, 31635, 31636, 31638-31643)	ZZZ	2.00 (RUC Recommendation from February 2009 Mtg – see Navigational Bronchoscopy)
Surgery **Respiratory System**				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Lungs and Pleura Introduction				
●⊙32553	T2	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple (Report supply of device separately) (For imaging guidance, see 76942, 77002, 77012, 77021) (For percutaneous placement of interstitial device[s] for intra-abdominal, intrapelvic, and or retroperitoneal radiation therapy guidance, use 49411)	000	3.80
Digestive System **Esophagus** **Abdomen, Peritoneum, and Omentum** **Laparoscopy**				
●⊙49411	T5	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic , and/or retroperitoneum including image guidance, if performed, single or multiple (For laparoscopic placement, use 49327) (Report supply of device separately) (For imaging guidance, see 76942, 77002, 77012, 77021) (For percutaneous placement of interstitial device[s] for intra-thoracic radiation therapy guidance, use 32553)	000	3.82

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Male Genital System **Prostate** **Other Procedures**				
E 55876		Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, prostate ~~(via needle, any approach)~~, single or multiple	000	1.73 (No Change)
Radiology **Diagnostic Ultrasound**				
76950		*Ultrasonic guidance for placement of radiation therapy fields* (For placement of interstitial device[s] for radiation therapy guidance, see 31627, 32553, 49410, 49411, 55876)	XXX	0.58 (No Change)
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, ~~use~~see 31627, 32553, 49410, 49411, 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 31627, 32553, 49410, 49411, 55876)	XXX	0.39 (No Change)

**Tracking Code Numbers T3 and T4 were rescinded by the CPT Editorial Panel

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31626 Tracking Number T1 Specialty Society Recommended RVU: **4.16**

Global Period: 000 RUC Recommended RVU: **4.16**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with placment of fiducial markers, single or multiple (Report supply of device separately) (Use 31626 in conjunction with 31615, 31627, 31623-31631, 31635, 31636, 31638-31643)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old smoker with COPD and lung cancer undergoes bronchoscopy to place fiducial markers into the airways or lung parenchyma.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 68% , In the ASC 68%, In the office 5%

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 68%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 100%

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

Description of Pre-Service Work: • Hospital outpatient or ASC admission and preprocedural work-up, review of records, communication with other professionals, patient and family.
- Obtain informed consent.
- The physician and staff dress in a disposable gown, non-sterile gloves, and protective eyewear before the procedures. Don lead apron for fluoroscopic guidance, if used.
- Preparing and positioning the patient and equipment.
- The physician examines the patient to verify that the patient can undergo the procedure.
- The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulations.

Description of Intra-Service Work: • The patient is placed on supplemental oxygen in the bronchoscopy suite which has resuscitative equipment in place.
- An IV is started and the physician supervised the nebulized administration of inhaled topical anesthesia.
- The physician next applies local topical anesthesia to the propharynx and nasopharanx.
- The physician than supervises administration of moderate sedation while a registered nurse or physician assistant properly monitors the pulse, blood pressure, SPO2, and ECG.

- The physician inserts the bronchoscope through the upper airways noting any abnormalities. The vocal cords are visualized and the structure and function are noted.
- Pre-mark the needle-catheter or dye marker delivery tool and place a tool-limit mark on the proximal side of the tool.Navigate and reach the desired targeted tumor(s). Load the syringe with the desired dye marker volume. Tl bronchoscope is advanced into the tracheobronchial tree noting any abnormalities. Load the syringe and/or catheter with the desired dye marker volume or fiducial marker. Insert the marker delivery tool into the catheter channel. Imaging (fluroscopy, ultrasound, or other) is used to verify placement and position of the delivery catheter or dye marker tool. Inject the dye marker into the soft lung tissue at target locations. Typically a median of 4 fiducial markers are placed. Remove the needle catheter or dye marker delivery tool.
- All steps in previous points are repeated until all targeted lesions and all markers have been placed.

Description of Post-Service Work: • The physician examines the patient post-bronchoscopy and pre-discharge from the facility to ascertain that no complications, such as bleeding, plugging, or shortness of breath have occurred.

- The findings from the bronchoscope are explained to the patient and/or family/friend
- The physician again reinforces previous instructions about post-procedure complications.
- The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Drs. Scott Manaker, Alan Plummer, Burt Lesnick and Kevin Kovitz				
Specialty(s):	American College of Chest Physicians (ACCP) and American Thoracic Society (STS)				
CPT Code:	31626				
Sample Size: 110	**Resp N:** 38	**Response:** 34.5 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	5.00	**10.00**	28.75	70.00
Survey RVW:	1.00	4.00	**4.16**	5.43	10.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	100.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	31626	**Recommended Physician Work RVU: 4.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

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

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	92,211

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance; diagnostic, including cell washing, when performed

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31600	000	7.17	**RUC Time**	40,512

CPT Descriptor 2 Tracheostomy, planned (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
31628	000	3.80	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 68.4 %

TIME ESTIMATES (Median)	CPT Code: 31626	Key Reference CPT Code: 31629	Source of Time RUC Time
Median Pre-Service Time	25.00	30.00	
Median Intra-Service Time	45.00	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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**85.00**	**80.00**	

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	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.34	4.19
Urgency of medical decision making	2.76	2.73

Technical Skill/Physical Effort (Mean)

Technical skill required	3.76	3.65
Physical effort required	4.20	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.50
Outcome depends on the skill and judgment of physician	4.76	4.15
Estimated risk of malpractice suit with poor outcome	3.96	3.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.88	3.53
Intra-Service intensity/complexity	4.38	4.11
Post-Service intensity/complexity	3.65	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.*

The Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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 service is typically performed by the same physician. For 2010, it is expected that this code will be reported with other bronchoscopy codes, 31615, 31623-31631, 31635, 31636, 31638-31643,3262X7. The Multiple Endoscopy Rule applys: total reimbursement is the full reimbursement for the most complex bronchoscopic procedure and the sum of the differences in reimbursement between each of the less complex codes and the base bronchoscopy code for a single patient. This means that other than the first reported highest RVU bronchoscopy code reported (eg, 31628, 31629), that each additional bronchoscopy code reported has -2.78 RVUs subtracted from the total RVW for that code, if reported alone.The surveyees were asked what other codes are typicall reported in addition to this code, and the response was:

31628 Bronchoscopy, rigid or flexible, including fluoroscopy; with transbronchial lung biopsy, single lobe (000) 3.80RVW 30/40/20=90 + add-on code for planning and navigation, 3162X7 Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with computer-assisted, image-guided navigation (ZZZ) +2.00RVW (if approved by CMS in the Nov. Final Rule)

Typical Scenario for 2009 Reporting of Bronchoscopic Placement of Fiducial Markers

CPT Code	Descriptor	Global Period	Work RVU	Pre/intra/post TIME (min)
31628	Bronchoscopy, rigid or flexible, with or without fluoroscopy; with transbronchial lung biopsy, single lobe	000	3.80	30/40/20=90
31629	Needle aspiration biopsy	000	4.09	30/30/20=80
31622	Base Bronchoscopy code included in 3162X6	000	2.78	20/30/15=65
3162X6	With placement of fiducial markers, single or multiple	000	Subtract 2.78 from final RVU because reported with 31628, 31629	
31623	Brushings	000	2.88-2.78 = 0.10	20/30/20=70 – 65 = 5
31624	Lavage	000	2.88-2.78 = 0.10	20/30/20=70 – 65 = 5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31899 unlisted code: see CPT Assistant, March 2008 said to report 76499, unlisted diagnostic radiographic 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 Pulmonary Medicidne How often? Sometimes

Specialty Thoracic Surgery How often? Sometimes

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. To date, both surveys indicate that this procedure is performed by Thoracic Surgeons 10% of the time.

Specialty Pulmonary Medicine Frequency 900 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 100 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? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 50% is a guess

Specialty Pulmonary Medicine Frequency 450 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 50 Percentage 10.00 %

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: 32553 Tracking Number T2 Specialty Society Recommended RVU: **4.99**

Global Period: 000 RUC Recommended RVU: **3.80**

CPT Descriptor: Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old male presents with a stage 1A non-small cell lung cancer in the right upper lobe. The patient has gold tracking fiducial implants inserted using a transthoracic approach.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 100%

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

Description of Pre-Service Work:
-Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
-Estimate the range of devices that may be required and ensure all are available for use
-Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
-Re-review applicable, available prior films

Description of Intra-Service Work:
-Check IV set up
-Supervise the positioning of the patient in a supine position
-Administer moderate sedation
-Prep and drape the chest
-Confirm tumor localization
-Apply local anesthesia for three needle entry sites
-Introduce preloaded gold fiducial markers into the periphery of the tumor in a triangular array
-Confirm placement of markers is within 2 mm of the tumor margin
-Verify complications such as bleeding, hematoma, and pneumothorax have not occurred

Description of Post-Service Work:
- Dictate operative report
- Review, revise and sign final report
- Communicate to the family and oncologist concerning number of markers placed and their location with respect to vi organs
- Discuss outcome with patient and family; remove family from location of fiducials

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009					
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Gerald Niedzwiecki, MD, Robert Volgelzang, MD					
pecialty(s):	SIR, ACR					
CPT Code:	32553					
Sample Size:	450	**Resp N:**	31	**Response:** 6.8 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		2.00	6.00	**10.00**	20.00	100.00
Survey RVW:		4.40	5.30	**5.70**	7.60	15.00
Pre-Service Evaluation Time:				**40.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		1.00	30.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

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

Specialty Society Recommended Data

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

CPT Code:	32553	**Recommended Physician Work RVU: 4.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		
Immediate Post Service-Time:	**20.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
ischarge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**		
ffice time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32998	000	5.68	RUC Time

CPT Descriptor Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	RUC Time	12,967

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 51.6 %

TIME ESTIMATES (Median)	CPT Code: 32553	Key Reference CPT Code: 32998	Source of Time RUC Time
Median Pre-Service Time	25.00	45.00	
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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**90.00**	**135.00**	

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	3.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.50
Urgency of medical decision making	2.88	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.94	4.06
Physical effort required	3.50	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	4.25
Outcome depends on the skill and judgment of physician	4.00	4.13
Estimated risk of malpractice suit with poor outcome	3.19	3.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.19	3.60
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	3.25	3.53

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.*

ACR and SIR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 32998 (Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by

tumor extension, percutaneous, radiofrequency, unilateral) with a work value of 5.68. The median work value for 32553 is 5.70, which was slightly higher than the reference service code. The panel felt the services are generally comparable since 3 or more separate fiducial placements are necessary, each requiring a new and different site of access and placement. Additionally, some of the intra-service time for 32988 is associated with the relatively low intensity work of waiting for thermal heating cycles to occur which accounts for the lower IWPUT of the reference service at 0.070. Further, as compared to 49411, there is additional time and effort is required to assess and evaluate for pneumothorax as it relates to placement of the additional markers. We believe that the fiducial marker placement codes can be likened to the placement of three central lines (36556) sequentially in the same patient. While it is difficult to accurately value that scenario, the example supports the higher intensity of 32553 as compared to the reference service.

We also recognize that our respondents included pre-service time above the standard RUC package applicable to this service. We recommend removing the pre-service time above those in the package and we recommended removing those RVUs from the 25th percentile value as well.

The panel recommends a value just below 25th percentile with a work value of **4.99** with the median physician time adjusted to the appropriate pre-service package of 39 min pre, 45 min intra, and 20 min post, which is considered appropriate for code 32553. The IWPUT for the reference service is 0.070. The IWPUT is 0.083 for code 32553 reflecting the difference in intensity discussed above.

Other 000 codes for comparison include,

	Work RVU	Pre	Intra	Post	
32550	4.17	40	30	20	Insertion of indwelling tunneled pleural catheter with cuff
58558	4.74	30	40	20	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C

These services have time and intensity in the same range as 3255X and support the societies' recommendation at 4.99 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.

		3255X plus	77002 or	77012 or	76942 or	77021
4.	Global	000	xxx	xxx	xxx	xxx
5.	Work RVU	4.99	.54	1.16	.67	1.50
6.	Pre	39				20
7.	Intra	45			30	42.50
8.	Post	20				15
9.	Total	104	12	22	30	77.50
10.						

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32999 and modality specific imaging guidance code

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

Specialty Radiology How often? Rarely

Specialty Interventional Radiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4251
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 32999 was previously used to report 3255X. The 2007 Medicare data estimates codes 32999 was billed approximately 1417. The overall number of services for 3255X in a one year period is estimated to be 4251.

Specialty Radiology Frequency 1870 Percentage 43.98 %

Specialty Interventional Radiology Frequency 382 Percentage 8.98 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,417 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 32999 was previously used to report 3255X. The 2007 Medicare data estimates codes 32999 was billed approximately 1417. Diagnostic radiology accounts for 628 and interventional radiology 123.

Specialty Radiology Frequency 628 Percentage 44.31 %

Specialty Interventional Radiology Frequency 123 Percentage 8.68 %

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? No

If no, please select another crosswalk and provide a brief rationale. CPT 31628 is a more reasonable crosswalk.

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: 49411 Tracking Number T5 Specialty Society Recommended RVU: **4.59**

Global Period: 000 RUC Recommended RVU: **3.82**

CPT Descriptor: Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old female presents with an unresectable pancreatic adenocarcinoma in the head of the pancreas. She has gold tracking fiducial implants inserted using a percutaneous approach.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 100%

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

Description of Pre-Service Work:
-Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
-Estimate the range of devices that may be required and ensure all are available for use
-Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
-Re-review applicable, available prior films

Description of Intra-Service Work:
-Check IV set up
-Supervise the positioning of the patient in a supine position
-Administer moderate sedation
-Prep and drape the abdomen
-Confirm tumor localization
-Apply local anesthesia for three needle entry sites
-Introduce preloaded gold fiducial markers into the periphery of the tumor in a triangular array
-Confirm placement of markers is within 2 mm of the tumor margin
-Verify complications such as bleeding and hematoma have not occurred

Description of Post-Service Work:
- Dictate operative report
- Review, revise and sign final report
-Communicate to the family and oncologist concerning number of markers placed and their location with respect to vi organs
- Discuss outcome with patient and family; remove family from location of fiducials

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Gerald Niedzwiecki, MD, Robert Volgelzang, MD				
Specialty(s):	SIR, ACR				
CPT Code:	49411				
Sample Size:	450	**Resp N:**	30	**Response:** 6.6 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	15.00	50.00
Survey RVW:	4.30	4.88	**6.00**	7.25	14.50
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	49411	**Recommended Physician Work RVU: 4.59**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**40.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
48102	010	4.68	**Harvard Time**

CPT Descriptor Biopsy of pancreas, percutaneous needle

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	12,967

CPT Descriptor 1 Cystourethroscopy with direct vision internal urethrotomy

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 78.5 %

TIME ESTIMATES (Median)	**CPT Code: 49411**	**Key Reference CPT Code: 48102**	**Source of Time Harvard Time**
Median Pre-Service Time	25.00	35.00	
Median Intra-Service Time	40.00	41.00	
Median Immediate Post-service Time	20.00	17.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	0.0	8.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**85.00**	**120.00**	
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	2.86	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	2.45
Urgency of medical decision making	2.73	2.36

Technical Skill/Physical Effort (Mean)

Technical skill required	3.82	2.95
Physical effort required	3.41	2.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	2.91
Outcome depends on the skill and judgment of physician	3.82	3.14
Estimated risk of malpractice suit with poor outcome	2.95	2.55

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.91	2.45
Intra-Service intensity/complexity	3.73	2.91
Post-Service intensity/complexity	2.77	2.41

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.*

ACR and SIR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 48102 (Biopsy of pancreas, percutaneous needle) with a work value of 4.68. The panel agreed with the survey respondents that as compared to the reference service, there is additional work in 49411 to place 3 or more separate fiducial

markers since each requires a new and different site of access and placement. However, what was likely not considered by the survey respondents was that 48102 is assigned a global period of 010 and includes 0.87 RVUs of post-service work within the global period that would be separately reportable for 49411. This makes the comparative value of 48102 3.81 RVU.

As such, we believe that the 25th percentile value of 4.88 more closely reflects the work for 49411. Additionally, we recognize that the intra-service time for the two codes is approximately the same but consider the work of 3 or more separate needle placements to be considerably more intense than the work of obtaining specimens after a single needle placement. We believe that the fiducial marker placement codes can be likened to the placement of three central lines (36556) sequentially in the same patient. While it is difficult to accurately value that scenario, the example reflects the higher intensity of 494X2 as compared to the reference service.

The panel recommends a value just below 25th percentile with a work value of **4.59** with the median physician time adjusted to the appropriate pre-service package of 39 min pre, 40 min intra, and 20 min post, which is considered appropriate for code 49411. The IWPUT for the reference service is 0.065. The IWPUT is 0.084 for code 49411 reflecting the difference in intensity discussed above.

Other 000 codes for comparison include,

	Work RVU	Pre	Intra	Post	
32550	4.17	40	30	20	Insertion of indwelling tunneled pleural catheter with cuff
58558	4.74	30	40	20	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C

These services have time and intensity in the same range as 494X2 and support the societies' recommendation at 4.59 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.

	494X2 plus	77002 or	77012 or	76942 or	77021
Global	000	xxx	xxx	xxx	xxx
Work RVU	4.59	.54	1.16	.67	1.50
Pre	39				20
Intra	40			30	42.50
Post	20				15
Total	99	12	22	30	77.50

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49999 and modality specific imaging guidance code

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

Specialty Radiology How often? Rarely

Specialty Interventional Radiology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3906
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 49999 was previously used to report 494X2. The 2007 Medicare data estimates code 49999 was billed approximately 1302. The overall number of services for 494X2 in a one year period is estimated to be 3906.

Specialty Radiology Frequency 352 Percentage 9.01 %

Specialty Interventional Radiology Frequency 96 Percentage 2.45 %

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? 1,302 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Code 49999 was previously used to report 494X2. The 2007 Medicare data estimates code 49999 was billed approximately 1302. Diagnostic radiology accounts for 121 and interventional radiology 32.

Specialty Radiology Frequency 121 Percentage 9.29 %

Specialty Interventional Radiology Frequency 32 Percentage 2.45 %

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. Surgical

CPT Code: 31626

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

CPT Long Descriptor: Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with placement of fiducial markers, single or multiple (Report supply of device separately) (Use 31626 in conjunction with 31615, 31627, 31623-31631, 31635, 31636, 31638-31643)

Global Period: 000

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expenses were developed by the American College of Chest Physician's (ACCP) Practice Management Committee and the American Thoracic Society (ATS) Clinical Practice Committee. There is good practice-type and geographic representation with the two pulmonary groups involved.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Hospital outpatient and ASC admission and preprocedural work-up, review of records, communication with other professionals, patient and family.**
- **Obtain informed consent.**
- **Dress in gown, non-sterile gloves and eye shield before the procedure. Don lead apron for fluoroscopic guidance, if used.**
- **Prepare and position the patient and equipment, following instructions by the physician.**
- **The RN/RT also verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulations.**

Intra-Service Clinical Labor Activities:

- **The patient is placed by the RN/RT on supplemental oxygen in the bronchoscopy suite which has resuscitative equipment in place.**
- **An IV is started by the RN/RT and the physician supervises the nebulized administration of inhaled topical anesthesia.**
- **The physician next applies local topical anesthesia to the propharynx and nasopharanx.**
- **Under moderate sedation, administered by the physician, the RN or PA properly monitors the pulse, blood pressure, SPO2, and ECG.**

Post-Service Clinical Labor Activities:

- **The RN/RT examines the patient post-bronchoscopy and pre-discharge from the facility to ascertain that no complications, such as bleeding, plugging, or shortness of breath have occurred.**
- **The findings from the bronchoscope are also explained to the patient and/or family/friend**
- **The RN/RT reinforces previous instructions about post-procedure complications.**

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

CPT Long Descriptor:
Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple

Sample Size:_N/A_____ Response Rate: (%): N/A_____Global Period:_000____

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:

The SIR and ACR convened a group of radiologists and interventional radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Follow-up phone calls and prescriptions

Post-Service Clinical Labor Activities:

- Conduct phone calls/call in prescriptions

Please see corresponding PERC spreadsheet for additional detail.

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

CPT Long Descriptor:
Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple

Sample Size:_N/A_____ Response Rate: (%): N/A_____Global Period:_000____

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:

The SIR and ACR convened a group of radiologists and interventional radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Complete pre-service diagnostic and referral forms
- Schedule space and equipment in facility
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities
- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/monitor patient
- Sedate/apply anesthesia
- Assist physician in performing procedure
- Assist physician Conscious Sedation monitoring; Assist physician monitoring
- Monitor patient following service/check tubes, monitors, drains. Recovery time is typically 2 hours with the patient is checked every 20 minutes for a minimum of 5 minutes (equivalent of 6 Level 2 vital checks).
- Check dressings and wound/home care instructions/coordinate office visits/prescriptions
- Clean room/equipment

Post-Service Clinical Labor Activities:

- Conduct phone calls/call in prescriptions

Please see corresponding PERC spreadsheet for additional detail.

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

CPT Long Descriptor:
Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple

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

The SIR and ACR convened a group of radiologists and interventional radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Follow-up phone calls and prescriptions

Post-Service Clinical Labor Activities

- Conduct phone calls/call in prescriptions

Please see corresponding PERC spreadsheet for additional detail.

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

CPT Long Descriptor:
Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple

Geographic Practice Setting %: All geographical practice setting 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 SIR and ACR convened a group of radiologists and interventional radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Complete pre-service diagnostic and referral forms
- Schedule space and equipment in facility
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities
- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/monitor patient
- Sedate/apply anesthesia
- Assist physician in performing procedure
- Assist physician Conscious Sedation monitoring; Assist physician monitoring
- Monitor patient following service/check tubes, monitors, drains. Recovery time is typically 2 hours with the patient is checked every 20 minutes for a minimum of 5 minutes (equivalent of 6 Level 2 vital checks).
- Check dressings and wound/home care instructions/coordinate office visits/prescriptions
- Clean room/equipment

Post-Service Clinical Labor Activities:
- Conduct phone calls/call in prescriptions

Please see corresponding PERC spreadsheet for additional detail.

	A	B	C	D	E
1	Tab 6 Bronchoscopic Placement of Fiducial Markers			31626	
2	Meeting Date: April 23 and 24, 2009 Chicago AMA/Specialty Society Update Committee Recommendation	CMS	Staff	with placement of fiducial markers, single or multiple (Report supply of device separately)	
3		Code	Type	Non Facility	Facility
4	GLOBAL PERIOD			000	000
5	TOTAL CLINICAL LABOR TIME			175.0	15.0
6	RN CLINICAL LABOR TIME			72.0	0.0
7	RN/RT CLINICAL LABOR TIME			103.0	12.0
8	TOTAL PRE-SERV CLINICAL LABOR TIME			14.0	15.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			161.0	0.0
10	PRE-SERVICE				
11	Start: Following visit when decision for surgery or procedure made				
12	Complete pre-service diagnostic & referral forms	L047C	RN/RT	5	5
13	Coordinate pre-surgery services	L047C	RN/RT	3	5
14	Schedule space and equipment in facility				3
15	Provide pre-service education/obtain consent	L047C	RN/RT	3	
16	Follow-up phone calls & prescriptions	L047C	RN/RT	3	2
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: Services Prior to Procedure				
21	Review charts	L047C	RN/RT	2	
22	Greet patient and provide gowning	L047C	RN/RT	3	
23	Obtain vital signs	L047C	RN/RT	5	
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies	L047C	RN/RT	2	
26	Setup scope (non facility setting only)	L047C	RN/RT	5	
27	Prepare and position patient/ monitor patient/ set up IV	L047C	RN/RT	2	
28	Sedate/apply anesthesia	L051A	RN	2	
29	Intra-service				
30	Assist Physician - conscious sedation = physician time	L051A	RN	45	
31	Assist Physician in performing procedure	L047C	RN/RT	30	
32	Post-Service				
33	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	25	
34	Clean room/equipment by physician staff	L047C	RN/RT	3	
35	Clean Scope	L047C	RN/RT	30	
36	Complete diagnostic forms, lab & X-ray requisitions	L047C	RN/RT	4	
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L047C	RN/RT	3	
39	End: Patient leaves office				
40	MEDICAL SUPPLIES		Unit		
41	pack, sleaning and disinfecting, endoscope	SA042	1	1	
42	pack, conscious sedation	SA044	1	1	
43	Pack, minimum multi-specialty visit	SA048	1	1	
44	syringe 10-12 ml	SC051	2	2	
45	syringe 50-60 ml	SC056	1	1	
46	suction specimen trap, sterile	SD121	1	2	
47	gauze, sterile 4in x 4in (10 pack uou)	SG056	10 pack	2	
48	lidocaine 1%-2% inj (Xylocaine)	SH047	40	40	
49	lidocaine 2% jelly, topical (Xylocaine)	SH048	5	5	
50	Lidocaine 4% soln, topical (Xylocaine)	SH050	20	20	
51	sodium chloride 0.9% inj (10ml uou)	SH066	1	1	
52	basin, emesis	SJ010	1	1	
53	denture cup	SJ016	1	1	
54	cup, biopsy-specimen sterile 4 oz	SL036	2	2	
55	eye shield, splash protection	SM016	2	2	
56	Needle Catheter, $18 sold by Taylor Pharmaceuticals		1	1	
57	Indigo Carmine, 5cc vials, sold in 10 pack from Taylor Pharmaceuticals $6 each		10 pack	2	
58	http://www.pharmaceuticalonline.com/storefronts/taylorpharm.html				
59	Equipment		1		
60	table, power	EF031	1	1	
61	ECG, 3-channel (with Sp02, NIBP, temp, resp)	EQ011	1	1	
62	IV infusion pump	EQ032	1	1	
63	pulse oximeter with printer	EQ211	1	1	
64	suction machine (Gomco)	EQ235	1	1	
65	fluoroscopic system, mobile C-Arm	ER031	1	1	
66	fiberscope, flexible, bronchoscope	ES017	1	1	
67	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031	1	1	
68	superDimension inREach navigational bronchosocpy system $137,800		1		
69	* (Use 31626 in conjunction with 31615, 3127, 31623-31631, 31635, 31636, 31638-31643)				
70	** (Use 31627 in conjunction with 31615, 31622-31631, 31635, 31636, 31638-31643, 31626)				

	A	B	C	D	E	F	G
1							
2				32553		49411	
3	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee Recommendation**			**Placement of interstitial device(s) for radiation therapy gudiance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple**		**Placement of interstitial device(s) for radiation therapy guidance 9eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**			**148.0**	**6.0**	**139.0**	**6.0**
7	**TOTAL CLINICAL LABOR PRE TIME**			**11.0**	**3.0**	**11.0**	**3.0**
8		L037D	RN/LPN/MTA	**11.0**	**3.0**	**11.0**	**3.0**
9		L046A	CT Tech				
10	**TOTAL CLINICAL LABOR INTRA TIME**			**134.0**		**125.0**	**0.0**
11		L037D	RN/LPN/MTA	**21.0**		**21.0**	
12		L046A	CT Tech	**36.0**		**32.0**	
13		L051A	RN	**77.0**		**72.0**	
14	**TOTAL CLINICAL LABOR POST TIME**			**3.0**	**3.0**	**3.0**	**3.0**
15		L037D	RN/LPN/MTA	**3.0**	**3.0**	**3.0**	**3.0**
16		L051A	RN				
17							
18	**PRE-SERVICE**						
19	**Start: Following visit when decision for surgery or procedure made**						
20	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5		5	
21	Coordinate pre-surgery services	L037D	RN/LPN/MTA				
22	Schedule space and equipment in facility	L037D	RN/LPN/MTA	3		3	
23	Provide pre-service education/obtain consent						
24	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
25	Other Clinical Activity (please specify):		CT Tech				
26	**End:When patient enters office/facility for surgery/procedure**						
27	**SERVICE PERIOD**						
28	**Start: When patient enters office/facility for surgery/procedure**						
29	**Pre-service services**						
30	Review charts	L037D	RN/LPN/MTA	2		2	
31	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3	
32	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
33	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7		7	
34	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
35	Setup scope (non facility setting only)						
36	Prepare and position patient/ monitor patient	L046A	CT Tech	2		2	
37	Sedate/apply anesthesia	L051A	RN	2		2	
38	**Intra-service**						
39	Assist physician in performing procedure	L046A	CT Tech	34		30	
40	Assist physician Conscious Sedation monitoring: Assist physician monitoring	L051A	RN	45		40	
41	**Post-Service**						
42	Monitor pt. following service/check tubes, monitors, drains. Recovery time is typically 2 hours with the patient is checked every 20 minutes for a minimum of 5 minutes (equivalent of 6 Level 2 vital checks)	L051A	RN	30		30	
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
44	Clean Scope						
45	Clean Surgical Instrument Package						
46	Complete diagnostic forms, lab & X-ray requisitions	L046A	CT Tech				
47	Review/read X-ray, lab, and pathology reports						
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	1		1	
49	Discharge day management 99238 –12 minutes 99239 –15 minutes	L051A	RN				
50	Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	CT Tech				
51	**End: Patient leaves office**						
52	**POST-SERVICE Period**						
53	**Start: Patient leaves office/facility**						
54	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
55	Office Visits:						
56	**List Number and Level of Office Vists**						
57	**99212 27 min**	L051A	RN				
58	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
2				32553		49411	
3	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee Recommendation**			**Placement of interstitial device(s) for radiation therapy gudiance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple**		**Placement of interstitial device(s) for radiation therapy guidance 9eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
59	MEDICAL SUPPLIES	CMS Code	Unit				
60	additional sterile gloves	SB024	pair	2		2	
61	applicator, sponge-tipped	SG009	item	4		4	
62	betadine (ml)	SJ041	ml	30		30	
63	blade, surgical (Bard-Parker)	SF033	item	1		1	
64	container, sterile 12 oz	SL038	item	1		1	
65	cup, biopsy-specimen sterile 4oz	SL036	item	1		1	
66	disinfectnat, surface (Envirocide, Sanizide)	SM013	item	1		1	
67	drape, sterile, fenestrated 16in x 29in	SB011	item	1		1	
68	drape, sterile, three-quarter sheet	SB014	item	1		1	
69	drape-towel, sterile 18inx26in	SB019	item	4		4	
70	fiduciary marker kit		item	3		3	
71	gauze, sterile 4in x 4in	SG055	item	3		3	
72	lidocaine	SH047	ml	30		30	
73	mask, surgical, with face shield	SB034	item	3		3	
74	pack, conscious sedation	SA044	item	1		1	
75	pack, min multi-specialty pack	SA047	item	1		1	
76	shoe covers, surgical	SB039	item	2		2	
77	silver nitrate stick	SJ046	item	1		1	
78	sodium chloride 0.9% irrigation (500-1000ml)	SH069	item	1		1	
79	steri-strips	SG074	item	6		6	
80	tape, surgical paper 1in (Micropore)	SG079	inch	12		12	
81	tincture benzoin swab	SJ060	item	1		1	
82	tray, Bx procedue	SA061	item	1		1	
83	tray, shave prep	SA067	item	1		1	
84	underpad 2ftx3ft (Chux)	SB044	item	1		1	
85	Equipment	CMS Code	Unit				
86	room, CT	EL007		45		40	
87	ECG, 3-channel (with Sp02, NIBR)	EQ011		75		70	
88	stretcher	EF018		75		70	
89	infusion pump	EQ032		75		70	
90	pulse oximeter	EQ211		75		70	
91	oxygen tank	EQ192		75		70	
92							
93							
94							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Navigational Bronchoscopy

In October 2008 the CPT Editorial Panel created a new add-on code to describe the pre-planning, real time navigation of the bronchus or placement of fiducial markers.

The RUC reviewed the specialty society recommendation for 31627 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with computer-assisted, image-guided navigation* and agreed with the physician time and work presented and supported by the survey median (60 minutes intra-service time and work RVU = 2.00). The RUC agreed that the physician work required for planning/mapping, downloading CT information and registering information typically would take 30 minutes and the actual performance of directional bronchoscopy would take an additional 30 minutes. The RUC compared 31627 to 31637 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented* (work RVU = 1.58, intra-service time = 30) and determined this supported the physician time and work required to perform 31627 as 31637 does not include an additional 30 minutes of planning and mapping. **The RUC recommends a work RVU of 2.00 for code 31627.**

Practice Expense
The RUC recommends the specialty society recommended practice expense inputs for the non-facility setting as attached.

New Technology
The RUC recommends that code 31627 be placed on the new technology list for future review.

Modifier -51 Exempt
The RUC recommends that code 31627 be placed on the Modifier-51 Exempt list as this procedure is typically performed with another procedure. The RUC recommended value is based on its Modifier -51 exempt status.

Moderate Sedation
The RUC recommends that 31627 be added to the Moderate Sedation List.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Ø 31622		Bronchoscopy, rigid or flexible, including ~~with or without~~ fluoroscopic guidance when performed; diagnostic, ~~with or without~~ cell washing when performed (separate procedure)	000	2.78 (No Change)
Ø•+31627	E1	with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s]) (31627 includes 3D reconstruction. Do not report 31627 in conjunction with 76376, 76377) (Use 31627 in conjunction with 31615, 31622-31631, 31635, 31636, 31638-31643)	ZZZ	2.00

63

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31627 Tracking Number E1 Specialty Society Recommended RVU: **2.00**

Global Period: ZZZ RUC Recommended RVU: **2.00**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with computer-assisted, image-guided navigation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old smoker has a single 9.0 mm lung nodule on CT of the chest. The peripheral nodule is not amenable to biopsy by routine bronchoscopy, so the patient is scheduled for navigational bronchoscopy.

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

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

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

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

s moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 74%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 19%

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

Description of Pre-Service Work:

Description of Intra-Service Work:
Planning Phase:
Pre-service part of intra-service physician work for the add-on code
Previously acquired CT scan of the lungs is imported into the planning laptop with special software for performing navigational bronchoscopy; a three-dimensional image of the patient's lungs is generated by the planning software; the physician marks the anatomical points and target lesion(s) on the virtual and CT images; the virtual and CT images are used to plan the path that the guide catheter (extended working channel) and the steerable navigation catheter (locatable guide) will follow in the bronchial tree; and the patient's virtual plan is saved and exported to a flash drive.

Navigation Phase – intra-service physician work
The patient's virtual plan is downloaded into the computer; moderate sedation is administered; The guide catheter and erable navigation catheter are inserted together (one inside the other) into the bronchoscope channel; CT images and eering directions on the monitor are used by the physician to navigate the guide catheter and steerable navigation catheter in real-time to target areas; the guide catheter is locked in place and the steerable navigation catheter is removed; and endobronchial tools are inserted through the guide catheter are used to collect tissue samples that are separately billed as a biopsy.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Drs. Eric Edell, Scott Manaker (ACCP) and Alan Plummer (ATS)				
Specialty(s):	ACCP and ATS				
CPT Code:	31627				
Sample Size:	110	**Resp N:**	53	**Response:** 48.1 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**20.00**	47.75	250.00
Survey RVW:	1.00	1.80	**2.00**	3.19	14.08
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	46.25	**60.00**	90.00	230.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	31627	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

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

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? 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
31637	ZZZ	1.58	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,273,273

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capcity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	3.52	**RUC Time**	271,044

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU	Time Source
31620	ZZZ	1.40	**RUC Time**

CPT Descriptor Endobronchial Ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure(s))

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

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 26.4 %

TIME ESTIMATES (Median)	CPT Code: 31627	Key Reference CPT Code: 31637	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
edian 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**	**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	4.21	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.14
Urgency of medical decision making	3.71	3.85

Technical Skill/Physical Effort (Mean)

Technical skill required	4.64	4.29
Physical effort required	4.21	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	4.29
Outcome depends on the skill and judgment of physician	4.78	4.64
Estimated risk of malpractice suit with poor outcome	3.71	3.79

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

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.43	4.11
Post-Service intensity/complexity		

Additional Rationale

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

The American College of Chest Physician's Practice Management Committee and the American Thoracic Society's Clinical Practice Committee reviewed the survey data and the practice expense inputs and are submitting their consensus documents for RUC review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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. Typical Scenario for 2008 Reporting of Navigational Bronchoscopy

	CPT Code	Descriptor	Global Period	Work RVU	Pre/intra/post		
4.	31628	Bronchoscopy, rigid or flexible, with or without fluoroscopy; with transbronchial lung biopsy, single lobe	000	3.80	30/40/20=90		
5.	76499	Unlisted diagnostic radiographic procedure – for planning	NA	NA	NA		
6.	31899	Unlisted procedure of the trachea or bronchi – for navigation	NA	NA	NA		

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31899

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 Medicine How often? Sometimes

Specialty Thoracic Surgery How often? Sometimes

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. surveyees provided percentage

Specialty Pulmonary Medicine Frequency 3600 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 400 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? 2,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated that the Medicare population is 50%.

Specialty Pulmonary Medicine Frequency 1800 Percentage 90.00 %

Specialty Thoracic Surgery Frequency 200 Percentage 10.00 %

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 Update Process
Practice Expense Summary of Recommendation
ZZZ Global Period
Non-Facility Direct Inputs
-Facility (if staff paid by physician and not bill separately, ie. NP/PA) and

CPT Long Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with computer-assisted, image-guided navigation

Process used to develop your PE recommendation: The practice expenses were developed by the ACCP Practice Management Committee and the American Thoracic Society Clinical Practice Committee. There is good practice-type and geographical representation with the two pulmonary groups involved.

Please describe the clinical activities of your staff: **Intra-Service Period Clinical Staff Labor:**
Pre-Operative

- Navigation system is prepared. Room configuration is checked/verified
- Bronchoscope is prepped with local guide catheter and endoscopic tools are marked
- Sensors are attached to the patient and patient is positioned over location board
- System operation and patient position are checked

Navigation phase

- RN assists in moderate sedation or general anesthesia of patient, when performed in OR
- Assist physician during the procedure which includes handling the locator guide, bronchoscope and breathing tube
- Monitor and manage system operations with both remote and touch screen, toggle between targets per physician instruction

Post-Operative

- Assist in shut down of navigation system

PHYSICIAN ACTIVITES FOLLOW:
Planning Phase:
Pre-service part of intra-service physician work for the add-on code

- Previously acquired CT scan of the lungs is imported into the planning laptop with special software for performing navigational bronchoscopy.
- A three-dimensional image of the patient's lungs is generated by the planning software.
- The physician marks the anatomical points and target lesion(s) on the virtual and CT images.
- The virtual and CT images are used to plan the path that the guide catheter (extended working channel) and the steer able navigation catheter (locatable guide) will follow in the bronchial tree.
- The patient's virtual plan is saved and exported to a flash drive.

Navigation Phase – intra-service physician work

- The patient's virtual plan is downloaded into the computer.
- Moderate sedation is monitored.
- The bronchoscope is inserted.
- The guide catheter and steer able navigation catheter are inserted together (one inside the other) into the bronchoscope channel.
- CT images and steering directions on the monitor are used by the physician to navigate the guide catheter and steer able navigation catheter in real-time to target areas.
- The guide catheter is locked in place and the steer able navigation catheter is removed.
- Endobronchial tools are inserted through the guide catheter are used to collect tissue samples that are separately billed as a biopsy.

	A	B	C	D	E	F	G
1				31628		31627	
2	**Meeting Date: January 29-February 1, 2009 AMA Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance;**		**with computer- assisted image-guided navigatio**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**ZZZ**	**ZZZ**
5	**TOTAL CLINICAL LABOR TIME**			**171.0**	**0.0**	**75.0**	**0.0**
6	RN CLINICAL LABOR TIME			67.0	0.0	30.0	0.0
7	RN/RT CLINICAL LABOR TIME			104.0	0.0	45.0	0.0
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**18.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**153.0**	**0.0**	**75.0**	**0.0**
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L047C	RN/RT	5			
13	Coordinate pre-surgery services	L047C	RN/RT	3			
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent	L047C	RN/RT	7			
16	Follow-up phone calls & prescriptions	L047C	RN/RT	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: Services Prior to Procedure**						
21	Review charts	L047C	RN/RT	2			
22	Greet patient and provide gowning	L047C	RN/RT	3			
23	Obtain vital signs	L047C	RN/RT	5			
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies	L047C	RN/RT	2		2	
26	Setup scope (non facility setting only)	L047C	RN/RT	5			
27	Prepare and position patient/ monitor patient/ set up IV	L047C	RN/RT	2		2	
28	Sedate/apply anesthesia	L051A	RN	2			
29	Power and System Preparation and attaching to bronchoscope	L047C	RN/RT			11	
30	**Intra-service**						
31	Assist Physician - conscious sedation = physician time	L051A	RN	40		30	
32	Assist Physician in performing procedure	L047C	RN/RT	27		30	
33	**Post-Service**						
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	25			
35	Clean room/equipment by physician staff	L047C	RN/RT	3			
36	Clean Scope	L047C	RN/RT	30			
37	Clean Surgical Instrument Package						
38	Complete diagnostic forms, lab & X-ray requisitions	L047C	RN/RT	4			
39	Review/read X-ray, lab, and pathology reports						
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L047C	RN/RT	3			
41	Discharge day management						
42	Other Clinical Activity (please specify)						
43	**End: Patient leaves office**						

	A	B	C	D	E	F	G
1				31628		31627	
2	**Meeting Date: January 29-February 1, 2009** **AMA Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance;**		**with computer- assisted image-guided navigation**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
44	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
45							
46	suction specimen trap, sterile	SD121	1	1			
47	syringe 10-12 ml	SC051	2	2			
48	eye shield, splash protection	SM016	2	2			
49	pack, sleaning and disinfecting, endoscope	SA042	1	1			
50	pack, conscious sedation	SA044	1	1			
51	Pack, minimum multi-specialty visit	SA048	1	1			
52	cup, biopsy-specimen sterile 4 oz	SL036	2	2			
53	basin, emesis	SJ010	1	1			
54	denture cup	SJ016	1	1			
55	lidocaine 1%-2% inj (Xylocaine)	SH047	40	40			
56	lidocaine 2% jelly, topical (Xylocaine)	SH048	5	5			
57	Lidocaine 4% soln, topical (Xylocaine)	SH050	20	20			
58	sodium chloride 0.9% inj (10ml uou)	SH066	1	1			
59	gauze, sterile 4in x 4in (10 pack uou)	SG056	10 pack	2			
60	superDimension patient sensor patches $1.10 each		1			3	
61	superDimension catheter kit: locatable guide, extended working channel, bronchoscope adapter and clip $995		1			1	
62	**Equipment**	**CMS Code**					
63	table, power	EF031	1	1			
64	ECG, 3-channel (with Sp02)	EQ011	1	1			
65	IV infusion pump	EQ032	1	1			
66	pulse oximeter with printer	EQ211	1	1			
67	suction machine (Gomco)	EQ235	1	1			
68	fluoroscopic system, mobile C	ER031	1	1			
69	endoscopic forceps, biopsy	ES006	1	1			
70	fiberscope, flexible, bronchoscope	ES017	1	1			
71	video system, endoscopy (pro	ES031	1	1			
72	superDimension inReach navigational bronchoscopy system $153,600		1			1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008

Tunneled Pleural Catheter

When the insertion of indwelling tunneled pleural catheter with cuff was initially developed, the majority of patients received this new procedure for symptomatic malignant pleural effusions as an end-of-life treatment. With increased usage of this catheter in malignant pleural effusions, it has become evident that the catheter can be removed in up to 70% of patients after successful resolution of the pleural effusion. Therefore the CPT Editorial Panel created a code to describe the removal of an indwelling pleural catheter with cuff to reflect this new practice pattern.

The RUC reviewed the specialty societies' survey data from 80 radiologists and thoracic surgeons for 32552 *Removal of indwelling tunneled pleural catheter with cuff.* The RUC compared the surveyed procedure to its reference code 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). Although the total service times of the surveyed code and the reference code are similar, 82 minutes and 79 minutes, respectively, the surveyed code is clearly a more intense procedure to perform. The specialty society explained and the RUC agreed that the surveyed code was a far more intense procedure to perform than the reference code for several reasons including: 1.) the surveyed procedure has 2-3 wound sites, whereas the reference procedure has 1 wound site, 2.) the surveyed procedure has a greater risk of pneumothorax as the catheter is going directly into the chest and 3.) due to the patient's cancer, the assessment of the patient is more extensive requiring a more extensive physical exam and a more extensive discussion with the patient and their family in comparison to the reference code. This difference between the surveyed code and the reference code is reflected in the survey data in the intensity complexity measures where the surveyed procedure has a greater level of intensity in all service time periods. Therefore, the RUC agrees with the specialty societies that the median work RVU of 2.50 RVUs for 32552 is appropriate as it maintains proper rank order with the reference code 36589. **The RUC recommends 2.50 RVUs for 32552.**

82

PLI Crosswalk:
The RUC established a new PLI crosswalk for 32552, its reference code 36589, as they determined this service would be more appropriate as it is closer in work RVUs to the proposed work for the surveyed code.

Practice Expense:
With the exception of a few minor changes to the pre-service time clinical labor inputs, the RUC agreed with the practice expense inputs recommended by the specialty societies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•32552	A1	Removal of indwelling tunneled pleural catheter with cuff	010	2.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 32552 Tracking Number A1 Specialty Society Recommended RVU: **2.50**

Global Period: 010 RUC Recommended RVU: **2.50**

CPT Descriptor: Removal of indwelling tunneled pleural catheter with cuff

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman with metastatic breast cancer undergoing chemotherapy had a tunneled pleural catheter inserted 8 weeks ago for a malignant pleural effusion. Patient records indicate that catheter drainage progressively slowed and ceased. Review of chest x-ray has demonstrated resolution of her effusion and re-expansion of the lung. She presents today for surgical removal of the catheter.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 43%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 18%

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

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

Description of Pre-Service Work: • Review patient history, medications and drainage history
- Review chest radiograph
- Review laboratory findings
- Answer patient and family questions
- Obtain informed consent
- Drain fluid if required
- Verify that all necessary surgical instruments and supplies are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Description of Intra-Service Work: • Administer conscious sedation if patient is unduly anxious
- Infiltrate catheter exit site and cuff site with appropriate local anesthesia
- Make small incision around catheter exit site and if necessary cuff site
- Dissect around catheter and cuff site to loosen catheter from surrounding tissue
- Grasp and gently remove entire catheter from within the chest
- Confirm entire catheter is removed
- Suture exit site of catheter
- Apply dressings

Description of Post-Service Work: • Dictate operative note for patients chart
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, films, medications, diet, and patient activity
- Discuss procedure outcome with patient and family
- Discuss procedure outcome with patient after emergence from anesthesia
- Write post-op report

- Carefully explain to patient and a family member dietary management, activities permitted, bathing, management of wound, return appointment to office, etc.
- Review post-discharge wound care and activity limitations with patient
- See patient back in the office to check wound, remove sutures, review chest radiograph and answer patient a family questions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Francis Nichols, MD, STS; John Mayer, MD, STS; Sean Tutton, MD, SIR; Robert Vogelzang, MD, SIR; Geralidine McGinty, MD, ACR				
Specialty(s):	STS, SIR, ACR				
CPT Code:	32552				
Sample Size: 950	**Resp N:** 80	**Response:** 8.4 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	9.00	50.00
Survey RVW:	0.50	2.29	**2.50**	3.30	6.30
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	32552	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**12.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
36589	010	2.27	**RUC Time**

CPT Descriptor Removal of tunneled central venous catheter, without subcutaneous port or pump

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11750	010	2.40	**RUC Time**	242,171

CPT Descriptor 1 Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
36590	010	3.32	**RUC Time**

CPT Descriptor Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion

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

Number of respondents who choose Key Reference Code: 46 **% of respondents:** 57.5 %

TIME ESTIMATES (Median)	CPT Code: 32552	Key Reference CPT Code: 36589	Source of Time RUC Time
Median Pre-Service Time	20.00	25.00	
Median Intra-Service Time	15.00	13.00	
Median Immediate Post-service Time	12.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	16.0	7.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**82.00**	**79.00**	

Other time if appropriate		

'NTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.04	1.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.22	1.78
Urgency of medical decision making	1.67	1.71

Technical Skill/Physical Effort (Mean)

Technical skill required	1.98	1.98
Physical effort required	1.82	1.84

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.96	1.96
Outcome depends on the skill and judgment of physician	2.04	1.96
Estimated risk of malpractice suit with poor outcome	1.78	1.76

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.07	1.83
Intra-Service intensity/complexity	2.05	2.02
Post-Service intensity/complexity	1.76	1.62

Additional Rationale

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

The IWPUT for 32552 based on the specialty society recommendations is 0.052
The IWUPT of reference code 36589 is also 0.052
The IWPUT of the second reference code is 0.046

The societies feel that the recommended value and IWPUT are representative for this procedure. The overwhelming number of patients are cancer patients who previously would have been considered end of life. Initially it was thought that the catheter would never be removed. It is now obvious that in a number of the patients the pleural effusion resolv and the catheter is no longer needed. Therefore the catheter is removed prior to end of life. The patient population w has their tunneled pleural catheter removed will still need to be followed by the physician to ensure that fluid accumulation remains resolved and they are still being followed for their cancer. It is important to see the patient back at least once after the removal of the catheter with x-ray confirmation and exam followed by discussion with the patient to ensure that the fluid and dyspnea is resolved.
The societies feel that this procedure is more complicated than the reference service procedure as reflected by the RVU and the differences in work. The survey procedure has two or three wound sites as opposed to one and the catheter is going into the chest with risk of pneumothorax. Due to the patient's cancer, the assessment of the patient is more extensive requiring a more extensive physical exam, a more extensive discussion with the patient and their family, and looking at the chest x-rays.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32999

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 Interventional Radiology How often? Sometimes

Specialty Radiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2402

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 2006 for tunneled pleural catheter insertion is 2883, it is estimated that approximately 60 % of the total number of patients are Medicare patients, which results in an estimated total frequency of 4805. Of this number, it is estimated that 50% of the catheters are ultimately removed which esults in 2,402 catheters removed yearly.

Specialty Cardiothoracic surgery Frequency 1152 Percentage 47.96 %

Specialty Interventional Radiology Frequency 408 Percentage 16.98 %

Specialty Radiology Frequency 240 Percentage 9.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,441 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The Medicare frequency for 2006 for tunneled pleural catheter insertion is 2883, it is estimated that approximately 50% of the catheters are ultimately removed which results in 1,441 Medicare catheters removed yearly.

Specialty Cardiothoracic Surgery Frequency 691 Percentage 47.95 %

Specialty Interventional Radiology Frequency 230 Percentage 15.96 %

Specialty Radiology Frequency 144 Percentage 9.99 %

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
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor: Removal of indwelling tunneled pleural catheter with cuff

Sample Size: 950 Response Rate: (%): 8.4% Global Period: 010

Geographic Practice Setting %: Rural 1% Suburban 25% Urban 59%

Type of Practice %: 5% Solo Practice
25% Single Specialty Group
18% Multispecialty Group
38% 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 Practice Expense Committee consisted of physician representatives from SIR, ACR and the STS.

'ease describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff fills out the pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. The clinical staff will educate the patient on what they need to do prior to the procedure including instructions to bring a bottle with them for pre-procedure drainage. The clinical staff will also call in any prescriptions necessary for the patient prior to the procedure as well as other offices and the patient to finalize the procedure.

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities

Discharge day management

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

CPT Long Descriptor: Removal of indwelling tunneled pleural catheter with cuff

Sample Size: 950 Response Rate: (%) 8.4% Global Period: 010

Geographic Practice Setting %: Rural 1% Suburban 25% Urban 59%

Type of Practice %: 5% Solo Practice
25% Single Specialty Group
18% Multispecialty Group
38% 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 PE committee consisted of physician representatives from SIR, ACR and the STS

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff will help with checking the patient in, putting them in the room and helping them gown if necessary. The clinical staff will provide pre-service education to the patient on what to expect for the procedure and obtain consent. They will prepare the room and set up the surgical tray and other necessary supplies and assist with positioning and administering the local anesthesia to the patient.

Intra-Service Clinical Labor Activities:

This is a sterile procedure therefore, once the clinical staff is gloved, they will remain in the room and assist the physician with the entire procedure.

Post-Service Clinical Labor Activities:

Once the procedure is completed the clinical staff will monitor the patient and help them get off the table and get dressed if necessary. They will check the dressing and provide the patient with information on how to care for their wound as well as activities they are allowed to participate in over the next several days. The clinical staff will also call in any prescriptions and coordinate follow-up care. The clinical staff will also clean the room and the surgical instruments used.

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**32552**	
2	**Meeting Date: October 2008**			**Removal of indwelling tunneled pleural catheter with cuff**	
3	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**
4	**GLOBAL PERIOD**			**10**	**10**
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**83**	**52**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**13**	**19**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**43**	**6**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**27**	**27**
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	**2**	**5**
12	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**3**	**3**
13	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**3**
14	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**5**	**5**
15	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**3**	**3**
16	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA		
17	**End:When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review charts	**L037D**	RN/LPN/MTA		
21	Greet patient and provide gowning	**L037D**	RN/LPN/MTA		
22	Obtain vital signs	**L037D**	RN/LPN/MTA		
23	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**3**	
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**	
25	Setup scope (non facility setting only)	**L037D**	RN/LPN/MTA		
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**	
27	Sedate/apply anesthesia	**L051A**	RN	**2**	
28	**Intra-service**				
29	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**15**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**3**	
32	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**	
33	Clean Scope	**L037D**	RN/LPN/MTA		
34	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**10**	
35	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA		
36	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA		
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**3**	
38	Discharge day management 99238 – 12 minutes, 99239 – 15 minutes	**L037D**	RN/LPN/MTA		**6**
39	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA		
40	**End: Patient leaves office**				
41	**POST-SERVICE Period**				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions	**L037D**			
45	*List Number and Level of Office Visits*				
46	99211 16 minutes		16		
47	99212 27 minutes		27	**1**	**1**
48	99213 36 minutes		36		
49	99214 53 minutes		53		
50	99215 63 minutes		63		
51	Other				
52	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**27**	**27**
53	Other				
54	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**32552**	
2	**Meeting Date: October 2008**			**Removal of indwelling tunneled pleural catheter with cuff**	
3	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**
55	**MEDICAL SUPPLIES**	**Code**	**Unit**		
56	pack, minimum multi-specialty visit	**SA048**	**pack**	**1**	**1**
57	pack, post-op incision care (suture)	**SA054**	**pack**	**1**	**1**
58	gloves, sterile	**SB024**	**pair**	**2**	
59	drape, sterile, for Mayo stand	**SB012**	**item**	**1**	
60	drape, sterile barrier 16in x 29in	**SB007**	**item**	**2**	
61	povidone swabsticks (3 pack uou)	**SJ043**	**item**	**1**	
62	needle, 18-27g	**SC029**	**item**	**2**	
63	syringe 10-12ml	**SC051**	**item**	**1**	
64	swab-pad, alcohol	**SJ053**	**item**	**2**	
65	lidocaine 1%-2% inj (Xylocaine)	**SH047**	**ml**	**20**	
66	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**item**	**1**	
67	**Equipment**	**Code**			
68	table, power	**EF031**		**1**	**1**
69	light, exam	**EQ168**		**1**	**1**
70	mayo stand	**EF015**		**1**	**1**
71	instrument pack, basic	**EQ137**		**1**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
April 2009

Chemical Pleurodesis

In February 2009, the CPT Editorial Panel created two new codes and revised one to describe the instillation of a fibrinolytic agent and provide further specificity to chemical pleurodesis. Chemical pleurodesis is the instillation of a chemical to get the visceral pleura of the lung to stick to the parietal pleura of the chest wall so the lung will not collapse. This revision to the definition allows the service to also be reported for fibrinolysis using a fibrinolytic agent. The revision to the descriptor also includes chemical instillation for fibrionlysis. The current code, 32560 *Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)* (2009 Work RVU = 2.19) by definition is specific to chemical pleurodesis and does not include fibrinolysis or the instillation of chemicals other than those to obtain symphysis of the visceral and parietal pleural surfaces for situations such as malignant pleural effusions or pneumothorax. The instillation of the fibrinolytic chemical is similar to the instillation of a pleurodesis agent or talc, the only difference is the type of chemical that is instilled into the chest. Fibrinolytics are designed to break up debris or fibrin within the chest thus freeing up an entrapped lung.

98

32560 *Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)*
The specialty recommended the survey 25th percentile, 2.00 work RVUs (lower than its current value in 2009 of 2.19 work RVUs), which the RUC agreed was too high. The RUC reviewed the recommended physician time for 32560, and after clarification from the specialty, it was agreed that pre-service time package 1A (Straightforward Patient/Procedure with No Sedation/Anesthesia) was appropriate however, because of the reviews of the chest radiograph and/or chest CT which is required given the location of the chest tube, status of lung inflation and potential presence of any residual fluid or air in the chest, the RUC agreed that an additional 5 minutes of pre-service evaluation time was required. The RUC also determined that the intra-service time as described by the specialty was best reflected with the surveyed median intra-service time, 20 minutes. After establishing the accurate service physician time (pre/intra/post=25/20/20), from the straightforward patient procedure without sedation/anesthesia pre-time standard and specialty survey, the RUC made comparisons to other codes with similar service times and intensities. These reference codes included 62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast* (Work RVU=1.54 and pre/intra/post times= 35/20/15), 32421 *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent* (Work RVU = 1.54, 000 day global, pre/intra/post times= 10/28/10) and 47525 *Change of percutaneous biliary drainage catheter* (Work RVU=1.54 and pre/intra/post times=25/20/10). **Based on these comparisons, the RUC recommends a work RVU of 1.54 for code 32560.**

32561 ***Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day***

The specialty recommended the survey 25th percentile of 1.80 work RVUs, which the RUC agreed was too high. The RUC reviewed the recommended physician time for 32561 and determined that the intra-service time as described by the specialty was best reflected with the surveyed median intra-service time, 15 minutes. After establishing the accurate service physician time (pre/intra/post=20/15/10), from the straightforward patient procedure without sedation/anesthesia and specialty survey, the RUC determined that the intra-service work intensity for 32561 is the same as 32560. Therefore, the RUC agreed to use a building block approach to value 32561. The RUC used the intra-service work per unit of time from 32560, 0.0309, and as there is a five minute difference in intra-service physician time between 32561 and 32560, removed 0.15 RVUs (0.0309 x 5 minutes) from the recommended value for 32560. This calculation results in 1.39 RVUs. This retains the relativity of the survey medians for these two services as well. The RUC further validated this recommended RVU by comparing the surveyed code to 36580 *Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (Work RVU=1.31 and pre/intra/post times=25/15/10), and 27096 (Work RVU = 1.40, 000 day global, pre/intra/post times= 10/25/5), and noted the similar intensities and service times. Based on these comparisons, **the RUC recommends a physician work relative value of 1.39 for CPT code 32561.**

99

32562 ***Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day***

The specialty recommended the survey 25th percentile, 1.50 Work RVUs, which the RUC agreed was too high. The RUC reviewed the recommended physician time for 32562 and determined that the intra-service time as described by the specialty was best reflected with the surveyed median intra-service time of 10 minutes. After establishing the accurate service physician time (pre/intra/post=20/10/10), from the straightforward patient procedure without sedation/anesthesia pre-time package and specialty survey, the RUC determined that the intra-service work intensity for 32562 is the same as 32560. Therefore, the RUC agreed to use a building block approach to value 32562. The RUC used the IWPUT of 32560, 0.0309, and as there is a 10 minute difference in intra-service physician time between 32562 and 32560, removed 0.30 RVUs (0.0309 x 10 minutes) from the recommended value for 32560. This calculation results in 1.18 RVUs (1.54 – 0.30). This retains the relativity of the survey medians for these two services as well. The RUC further validated this recommended RVU by comparing the surveyed code to 67505 *Retrobulbar injection; alcohol* (Work RVU=1.27 and pre/intra/post times=25/10/5), 27096 (Work RVU = 1.40, 000 day global, pre/intra/post times= 10/25/5), and 36516 *Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion* (Work RVU = 1.22, 000 day global, pre/intra/post times = 25/15/10) and noted the similar intensities and service times. Based on these comparisons, **the RUC recommends a physician work relative value of 1.24 for CPT code 32562.**

Practice Expense
The RUC agreed that although these services are predominately performed in the inpatient facility setting, the services may be rarely performed in the non-facility setting. The RUC reviewed the direct practice expense inputs for the non-facility setting and recommended by the specialty society and made no edits other than adjust the assist physician time to be equal to 100% of the physician intra-service work time. The RUC agreed that there are no direct practice expense inputs in the facility setting for these services.

Work Neutrality
The RUC recommendations for this issue result in a work value savings to be redistributed via the conversion factor.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
The instillation of a fibrinolytic agent may be performed mutiple times per day over the course of several days. Code 32561 should be reported only once on the initial day of treatment. Code 32562 should be reported only once on each subsequent day of treatment			
▲ 32560	Instillation, via chest tube/catheter, ~~Cchemical~~ agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax) (For chest tube insertion, use 32551)	000	1.54
●32561	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day (For chest tube insertion, use 32551)	000	1.39
●32562	subsequent day (For chest tube insertion, use 32551)	000	1.24

100

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32560 Tracking Number U1 Specialty Society Recommended RVU: **2.00**

Global Period: 000 RUC Recommended RVU: **1.54**

CPT Descriptor: Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)(For chest tube insertion, use 32551)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old man presents with shortness of breath. The patient has had two previous pneumothoraces and the present chest x-ray shows right pneumothorax, which was treated through a previously placed chest tube. Talc pleurodesis is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 53%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 73%

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

Description of Pre-Service Work: The patient's medical record is reviewed and the chest radiograph and or chest CT is reviewed with special attention to the location of the chest tube, status of lung inflation and presence of any residual fluid or air in the chest. The status of the indwelling chest tube with regards to drainage and air leak is ascertained. The procedure is explained to the patient and informed consent is obtained. The drug is ordered from the pharmacy. Materials needed for the procedure are gathered at the patient's bedside.

Description of Intra-Service Work: The patient is positioned. The connection between the chest tube and drainage unit is prepped and draped in sterile fashion. Clamps are placed on either side of the connection and the tube is disconnected from the drainage hose. A syringe containing the chemical is inserted into the chest tube, the clamp is removed from the tube and the chemical is gently injected over several minutes into the thoracic cavity. The clamp is reapplied on the chest tube which is reconnected to the drainage unit. The patient is sequentially moved to each of six positions to distribute the chemical throughout the pleural cavity and the chemical is left to dwell in the chest cavity for typically about 30 minute Thereafter the clamp is removed and suction reinstituted.

Description of Post-Service Work: Pain is assessed and treated if present after pleurodesis. A chest radiograph is ordered and reviewed to ensure the lung is well inflated. A procedure report is either dictated or written into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009
Presenter(s):	Keith Naunheim, MD, STS; Scott Manaker, MD , ACCP; Burt Lesnick, MD, ACCP; Alan Plummer, MD for ATS
Specialty(s):	STS/AATS/ACCP/ATS
CPT Code:	32560
Sample Size: 80	**Resp N:** 30 — **Response:** 37.5 %
Sample Type:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**5.50**	27.50	400.00
Survey RVW:	1.00	2.00	**2.78**	3.50	8.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	15.00	**20.00**	30.00	75.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	32560	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**13.00**	**5.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**20.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32551	000	3.29	**RUC Time**

CPT Descriptor Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	92,211

CPT Descriptor 1 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
32421	000	1.54	**RUC Time**	124,935

CPT Descriptor 2 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent

Other Reference CPT Code	Global	Work RVU	Time Source
31615	000	2.09	**Harvard Time**

CPT Descriptor Tracheobronchoscopy through established tracheostomy incision

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 23.3 %

TIME ESTIMATES (Median)	CPT Code: 32560	Key Reference CPT Code: 32551	Source of Time RUC Time
Median Pre-Service Time	25.00	46.00	
Median Intra-Service Time	20.00	24.00	
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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**65.00**	**95.00**	

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	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.63
Urgency of medical decision making	3.75	3.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	4.00
Physical effort required	4.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.75
Outcome depends on the skill and judgment of physician	3.75	3.63
Estimated risk of malpractice suit with poor outcome	4.13	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	4.00
Intra-Service intensity/complexity	3.75	3.63
Post-Service intensity/complexity	3.38	3.25

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 felt that the 25th percentile was more representative for the intraservice time and work values, therefore the STS/ACCP/ATS recommend an RVW of 2.0 with an intra-service time of 15 minutes for an IWPUT of 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) 32560

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 Cardiothoacic Surgery How often? Commonly

Specialty Pulmonary Disease How often? Commonly

Specialty General Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 9175
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. For Medicare, 6,423 procedures are done each year and Medicare accounts for approximately 70% of the procedures.

Specialty Cardiothoracic surgery Frequency 3762 Percentage 41.00 %

Specialty Pulmonary Disease Frequency 2491 Percentage 27.14 %

Specialty General Surgery Frequency 1452 Percentage 15.82 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,423 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty
Please explain the rationale for this estimate. based on current RUC database data

Specialty Cardiothoracic surgery Frequency 2633 Percentage 40.99 %

Specialty Pulmonary Disease	Frequency 1734	Percentage 26.99 %
Specialty General Surgery	Frequency 1091	Percentage 16.98 %

)o 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. 32421

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:32561 Tracking Number U2 Specialty Society Recommended RVU: **1.80**

Global Period: 000 RUC Recommended RVU: **1.36**

CPT Descriptor: Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day
(For chest tube insertion, use 32551)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old diabetic woman presents with right lower lobe pneumonia and a complicated parapneumonic effusion, a chest tube was previously placed for drainage. A chest CT confirms several sizable loculations. Instillation of fibrinolysis through the existing chest tube is recommended.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 53%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

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

Description of Pre-Service Work: The patient's medical record is reviewed and the chest radiograph and or chest CT is reviewed with special attention to the location of the chest tube, status of lung inflation and presence of any residual fluid or air in the chest. The status of the indwelling chest tube with regards to drainage and air leak is ascertained. The procedure is explained to the patient and informed consent is obtained. The drug is ordered from the pharmacy. Materials needed for the procedure are gathered at the patient's bedside.

Description of Intra-Service Work: The patient is positioned. The connection between the chest tube and drainage unit is prepped and draped in sterile fashion. Clamps are placed on either side of the connection and the tube is disconnected from the drainage hose. A syringe containing the fibrinolytic agent is inserted into the chest tube, the clamp is removed from the tube and the fibrinolytic agent is injected into the thoracic cavity. The clamp is replaced on the chest tube which is reconnected to the drainage unit. The patient is sequentially moved to each of six positions to distribute the fibrinolyt agent throughout the pleural cavity for 2 hours. Thereafter the clamp is removed and suction reinstituted.

Description of Post-Service Work: A chest radiograph is ordered and reviewed to ensure the lung is well inflated. A procedure report is either dictated or written into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	,Keith Naunheim, MD, STS; Scott Manaker, MD , ACCP; Burt Lesnick, MD, ACCP; Alan Plummer, MD for ATS				
Specialty(s):	STS/AATS/ACCP/ATS				
CPT Code:	32561				
Sample Size:	80	**Resp N:**	30	**Response:** 37.5 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.25	**5.00**	10.00	50.00
Survey RVW:	1.00	1.80	**2.50**	3.35	8.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	10.00	**15.00**	30.00	75.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	32561	**Recommended Physician Work RVU: 1.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**15.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32551	000	3.29	**RUC Time**

CPT Descriptor Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	92,211

CPT Descriptor 1 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	2.50	**RUC Time**	582,643

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
32421	000	1.54	**RUC Time**

CPT Descriptor Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 23.3 %

TIME ESTIMATES (Median)	CPT Code: 32561	Key Reference CPT Code: 32551	Source of Time RUC Time
Median Pre-Service Time	20.00	46.00	
Median Intra-Service Time	15.00	24.00	
Median Immediate Post-service Time	10.00	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	**45.00**	**95.00**	

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	3.86	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.71
Urgency of medical decision making	3.86	3.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	4.14
Physical effort required	4.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.86
Outcome depends on the skill and judgment of physician	3.86	3.71
Estimated risk of malpractice suit with poor outcome	3.71	3.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.71	3.57
Intra-Service intensity/complexity	3.86	3.71
Post-Service intensity/complexity	3.43	3.29

Additional Rationale

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

The specialties were asked to include the following questions in the survey to identify how often these procedures would be performed and what fibrinolytic agent is typically used for the procedures. The questions and responses are as follows (responses for the first three questions are based on the median survey value):

What is the typical number of fibrinolytic instillations performed on the initial day (3256X)?
Median – 1/day

What is the typical number of fibrinolytic instillations performed each subsequent day (3256X1)?
Median – 1/day

What is the typical number of days in a row that fibrinolytic instillations will be provided to a patient?
Median – 3 days

What is the typical agent used for fibrinolytic instillations (eg. streptokinease, tissue plasminogen activator-TPA, etc...)?
70% of respondents indicated that TPA was the typical agent

The Societies feel that the 25th Percentile is more representative of the work involved in the procedure and recommends that the 25th Percentile time and RVW be used for this code which results in an RVW of 1.80 and an intra time of 10 minutes, which results in an IWPUT of 0.121 for the procedure with pre-time package 1a.

SERVICES REPORTED WITH MULTIPLE 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) HCPCS code for alteplase - TPA (tissue plasminogen activator)

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. J2997

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32560

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 Cardiothoacic Surgery How often? Commonly

Specialty Pulmonary Disease How often? Commonly

Specialty General Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 917
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The fibrinolytic procedures is estimated to add about 10% more cases to the pleurodesis procedure

Specialty Cardiothoracic surgery Frequency 375 Percentage 40.89 %

Specialty Pulmonary Disease Frequency 249 Percentage 27.15 %

Specialty General Surgery Frequency 145 Percentage 15.81 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 642
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. based on 10% of current RUC database data for pleurodesis

Specialty Cardiothoracic surgery Frequency 263 Percentage 40.96 %

Specialty Pulmonary Disease Frequency 174 Percentage 27.10 %

Specialty General Surgery Frequency 102 Percentage 15.88 %

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. 94003

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:32562 Tracking Number U3 Specialty Society Recommended RVU: **1.50**

Global Period: 000 RUC Recommended RVU: **1.18**

CPT Descriptor: Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day
(For chest tube insertion, use 32551)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old diabetic woman presents with right lower lobe pneumonia and a complicated parapneumonic effusion, through a previously placed chest tube. A chest CT confirms several sizable loculations. Instillation of fibrinolysis is recommended. The patient had an initial treatment with a fibrinolytic agent with only a partial response and thus requires subsequent treatments through the existing chest tube

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 87%

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

Description of Pre-Service Work: The chest radiograph and or chest CT is reviewed with special attention to the location of the chest tube, status of lung inflation and presence of any residual fluid or air in the chest. The status of the indwelling chest tube with regards to drainage and air leak is ascertained. The drug is ordered from the pharmacy. Materials needed for the procedure are gathered at the patient's bedside.

Description of Intra-Service Work: The patient is positioned. The connection between the chest tube and drainage unit is prepped and draped in sterile fashion. Clamps are placed on either side of the connection and the tube is disconnected from the drainage hose. A syringe containing the fibrinolytic agent is inserted into the chest tube, the clamp is removed from the tube and the fibrinolytic agent is injected into the thoracic cavity. The clamp is replaced on the chest tube which is reconnected to the drainage unit. The patient is sequentially moved to each of six positions to distribute the fibrinolyt agent throughout the pleural cavity for 2 hours. Thereafter the clamp is removed and suction reinstituted.

Description of Post-Service Work: A chest radiograph is ordered and reviewed to ensure the lung is well inflated. A procedure report is either dictated or written into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Keith Naunheim, MD, STS; Scott Manaker, MD , ACCP; Burt Lesnick, MD, ACCP; Alan Plummer, MD for ATS				
Specialty(s):	STS/AATS/ACCP/ATS				
CPT Code:	32562				
Sample Size:	80	**Resp N:**	30	**Response:** 37.5 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	10.00	50.00
Survey RVW:	0.50	1.50	**2.00**	2.90	4.80
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	0.00	10.00	**10.00**	15.00	60.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-Straightforw Pat/Procedure(no sedation/anesthes

CPT Code:	32562	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**10.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32421	000	1.54	**RUC Time**

CPT Descriptor Thoracentesis, puncture of pleural cavity for aspiration, 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	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	92,211

CPT Descriptor 1 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
32422	000	2.19	**RUC Time**	91,633

CPT Descriptor 2 Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
32551	000	3.29	**RUC Time**

CPT Descriptor Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)

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

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 36.6 %

TIME ESTIMATES (Median)	CPT Code: 32562	Key Reference CPT Code: 32421	Source of Time
Median Pre-Service Time	20.00	10.00	
Median Intra-Service Time	10.00	28.00	
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	**40.00**	**48.00**
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	3.18	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.91	2.36
Urgency of medical decision making	2.82	2.55

Technical Skill/Physical Effort (Mean)

Technical skill required	2.82	3.18
Physical effort required	2.73	3.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.91	3.00
Outcome depends on the skill and judgment of physician	2.91	2.91
Estimated risk of malpractice suit with poor outcome	3.09	2.91

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

Time Segments (Mean)

Pre-Service intensity/complexity	2.82	2.82
Intra-Service intensity/complexity	2.36	2.82
Post-Service intensity/complexity	2.36	2.18

Additional Rationale

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

The specialties were asked to include the following questions in the survey to identify how often these procedures would be performed and what fibrinolytic agent is typically used for the procedures. The questions and responses are as follows (responses for the first three questions are based on the median survey value):

What is the typical number of fibrinolytic instillations performed on the initial day (3256X)?
Median – 1/day

What is the typical number of fibrinolytic instillations performed each subsequent day (3256X1)?
Median – 1/day

What is the typical number of days in a row that fibrinolytic instillations will be provided to a patient?
Median – 3 days

What is the typical agent used for fibrinolytic instillations (eg. streptokinease, tissue plasminogen activator-TPA, etc...)?
70% of respondents indicated that TPA was the typical agent

The Societies feel that the 25th Percentile is more representative of the work involved in the procedure and therefore recommend that an RVW of 1.50 and an intra time of 10 minutes be use which results in an IWPUT of 0.091 for the procedure with pre-time package 1a.

SERVICES REPORTED WITH MULTIPLE 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) HCPCS code for alteplase - TPA (tissue plasminogen activator)

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. J2997

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32560

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 Cardiothoacic Surgery How often? Commonly

Specialty Pulmonary Disease How often? Commonly

Specialty General Surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1834
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 would be double the initial code, one instillation per day after the initial for 2 days.

Specialty Cardiothoracic surgery Frequency 752 Percentage 41.00 %

Specialty Pulmonary Disease Frequency 498 Percentage 27.15 %

Specialty General Surgery Frequency 290 Percentage 15.81 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,284 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. he frequency would be double the initial code, one instillation per day after the initial for 2 days.

Specialty Cardiothoracic surgery Frequency 526 Percentage 40.96 %

Specialty Pulmonary Disease Frequency 349 Percentage 27.18 %

Specialty General Surgery Frequency 203 Percentage 15.80 %

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. 96570

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

CPT Code:_____
Specialty Society('s)_____

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

CPT Long Descriptors:

32560 – Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax

32651 – Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day

32652 – Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day

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

Crosswalk to existing code 32560 and expert panel review

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

32560 – The clinical staff will educate the patient on the procedure and obtain consent from the patient for the procedure

32651 – The clinical staff will educate the patient on the procedure and obtain consent from the patient for the procedure

32652 – The clinical staff will educate the patient on the procedure and obtain consent from the patient for the procedure

Intra-Service Clinical Labor Activities:

32560

During the intra-service time the clinical staff will greet the patient, provide gowning and obtain vital signs from the patient. They will prepare the room including laying out the supplies and preparing the necessary equipment. The clinical staff will assist with preparing and positioning the patient for the procedure. The procedure is typically performed with conscious sedation in the office so the staff will also set up the IV, help sedate the patient and help monitor the patient during the procedure.

The procedure is a sterile procedure so the clinical staff will assist the physician in instilling the talc and be sterilely gloved though the entire procedure.

Once the procedure is completed, the clinical staff will be responsible for monitoring the patient following the conscious sedation and will monitor the chest tube for drainage. The clinical staff will also clean the room and equipment once the procedure is completed.

32651

During the intra-service time the clinical staff will greet the patient and provide gowning and obtain vital signs from the patient. They will prepare the room including laying out the supplies and preparing the necessary equipment. The clinical staff will assist with preparing and positioning the patient for the procedure.

The procedure is a sterile procedure so the clinical staff will assist the physician in instilling the TPA and be sterilely gloved though the entire procedure.

Once the procedure is completed, the clinical staff will be responsible for monitoring chest tube for drainage. The clinical staff will also clean the room and equipment once the procedure is completed.

32652

During the intra-service time the clinical staff will greet the patient and provide gowning and obtain vital signs from the patient. They will prepare the room including laying out the supplies and preparing the necessary equipment. The clinical staff will assist with preparing and positioning the patient for the procedure.

The procedure is a sterile procedure so the clinical staff will assist the physician in instilling the TPA and be sterilely gloved though the entire procedure.

Once the procedure is completed, the clinical staff will be responsible for monitoring chest tube for drainage. The clinical staff will also clean the room and equipment once the procedure is completed.

	A	B	C	D	E	F	G	H	I
1				32560		32561		32562	
2	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee** **Recommendation**	**CMS**	**Staff**	Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)		Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day		subsequent day	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**								
5	**TOTAL CLINICAL LABOR TIME**			**44.0**	**0.0**	**32.0**	**0.0**	**27.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**41.0**	**0.0**	**29.0**	**0.0**	**24.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**								
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	L047C		**3**		**3**		**3**	
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	**SERVICE PERIOD**								
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
20	Review charts	L047C		**3**		**3**		**3**	
21	Greet patient and provide gowning	L047C		**3**		**3**		**3**	
22	Obtain vital signs	L047C		**3**		**3**		**3**	
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies	L047C		**2**		**2**		**2**	
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV	L047C		**2**					
27	Sedate/apply anesthesia	L047C		**2**					
28	**Intra-service**								
29	Assist physician in performing procedure	L047C		**20**		**15**		**10**	
30	**Post-Service**								
31	Monitor pt. following service/check tubes, monitors, drains	L047C		**3**					
32	Clean room/equipment by physician staff	L047C		**3**		**3**		**3**	
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
38	Discharge day management								
39	Other Clinical Activity (please specify)								
40	**End: Patient leaves office**								
41	**POST-SERVICE PERIOD**								
42	**Start: Patient leaves office/facility**								
43	**MEDICAL SUPPLIES**		**Unit**						
44	gloves, sterile	SB024		**2**		**2**		**2**	
45	gown, staff, impervious	SB027		**2**		**2**		**2**	
46	needle, 19 - 25g, butterfly	SC030		**1**		**1**		**1**	
47	syringe 5 - 6 ml	SC057		**1**		**1**		**1**	
48	pack, minimum multi-specialty visit	SA048		**1**		**1**		**1**	
49	talc, sterele (Sclerosol) (4gm uou)	SH070		**1**					
50	**EQUIPMENT**								
51	Table, exam	EF023							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008

Nikaidoh Procedure

The CPT Editorial Panel created two codes to describe a new repair technique applied to children suffering from transposition of the great arteries with ventricular septal defect and pulmonary stenosis.

33782
The RUC reviewed the specialty survey society data from 40 thoracic surgeons for 33782 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation reconstruction.* The RUC noted that the reference code, 33413 *Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)* (Work RVU=59.74), selected by the survey respondents was very similar to the surveyed code. The reference code and the surveyed code have very similar intra-service times, 297 minutes and 300 minutes, respectively. The intensities for the surveyed code were slightly higher than the reference code, which the specialty society explained was due to the typical patient being a 14 month old child as opposed to the reference code which is performed on an adult. The RUC agreed that due to the very similar intra-service times and slightly higher intensities as compared to the reference code, 33782 is appropriately valued at 60.00 RVUs, the survey median. **The RUC recommends 60.00 RVUs for 33782.**

33783
The RUC reviewed the specialty society survey data from 40 thoracic surgeons for 33783 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia.* The RUC noted that the reference code, 33413 *Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)* (Work RVU=59.74), selected by the survey respondents was less difficult to perform than the surveyed code. The reference code has significantly less intra-service time than the surveyed code, 297 minutes and 360 minutes, respectively. The intensities for the surveyed code were higher than the reference code, which the specialty society explained was due to the typical patient being a 12 month old child as opposed to the reference code which is performed on an adult. In addition, the surveyed code requires additional suture lines and physicians have to control has more bleeding as compared to the reference code. The RUC agreed that due to the higher intra-service times and higher intensities as compared to the reference code, 33783 is appropriately valued at 65.00 RVUs. **The RUC recommends 65.00 RVUs for 33783.**

PLI Crosswalk
The RUC agreed with the specialty society that 33413 is an appropriate PLI crosswalk for 33782 as they are similarly valued and performed by the same specialty. However, the RUC established a new PLI crosswalk for 33783, 33980 *Removal of ventricular assist device, implantable intracorporeal, single ventricle* (Work RVU=64.86) as they determined this service would be more appropriate as it is closer in work RVUs to the proposed work for the surveyed code.

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•33782	B1	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation reconstruction (Do not report 33782 in conjunction with 33412, 33413, 33608, 33681, 33770, 33771, 33778, 33780, 33920)	090	60.00
•33783	B2	with reimplantation of 1 or both coronary ostia	090	65.00

127

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33782 Tracking Number B1 Specialty Society Recommended RVU: **60.00**

Global Period: 090 RUC Recommended RVU: **60.00**

CPT Descriptor: Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation

(Do not report 33782 in conjunction with 33412, 33413, 33608, 33681, 33770, 33771, 33778, 33780, 33920)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-month-old boy was born with mild cyanosis and a heart murmur. Echocardiography at birth revealed transposition of the great arteries (discordant ventricular-arterial connections) with ventricular septal defect and left ventricular outflow tract obstruction. The child's oxygen saturation on room air was 85% at birth and remained between 80% and 90% throughout the first 14 months of life. At age 14 months, the oxygen saturations began to fall to the 70% range and the child was referred for surgical intervention secondary to falling oxygen saturation levels.

At age 14 months, therefore, the child's clinical and echocardiographic data was reviewed at Joint Cardiology and Cardiac Surgery Conference and the decision was made to proceed with a Nikaidoh procedure (Aortic root translocation over left ventricle).

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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

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

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

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

Description of Pre-Service Work:
Write preoperatve orders, review pertinent clinical information. Talk with family and coordinate with facilty and other physicians. Wait for induction of anesthesia and insertion of lines. Position patient. Scrub and gown, prep and drape.

Description of Intra-Service Work: Under general endotracheal anesthesia, in the supine position, the patient is prepped and draped in standard aseptic fashion. Skin incision made via standard median sternotomy. Sternum is divided in the midline. Cardiac cannulae placed. Cardiopulmonary bypass initiated. Snares are snugged down on the caval cannulae allowing for complete heart bypass. The aorta is mobilized as are the proximal coronary arteries. With the heart still perfused, the aortic root is dissected off the right ventricle with the coronaries intact. The aorta is crossclamped and cold cardioplegic solution is injected into the aortic root. The ascending aorta is divided just below the crossclamp. The pulmonary artery is opened longitudinally with the incision carried down across the pulmonary annulus to the VSD thus creating unobstructed left ventricular outflow. Septal muscle is excised as necessary. The aortic root is now translocated

posteriorly with the back wall sewn to the remnant of the pulmonary valve annulus. A patch is used to close the VSD, which superiorly attaches to the anterior wall of the proximal aortic root thus providing unobstructed flow from the LV to the aorta. The pulmonary bifurcation is widely mobilized and brought anterior to the distal ascending aorta (the LeCompte maneuver). An end-to-end anastomosis is performed between the proximal ascending aorta and the dis' ascending aorta. Right ventricular to pulmonary artery continuity is established either with a valved conduit or attaching the posterior wall of the main pulmonary artery remnant to the right ventricle and roofing it with a non-valved patch. Air is evacuated from the cardiac chambers and the crossclamp is released. After satisfactory rewarming and resuscitation, the child is then weaned from cardiopulmonary bypass. The cannulae are removed and the sites secured. Chest tubes and temporary pacing wires are placed. The sternum is closed with wires, the abdominal fascia, skin and subcutaneous tissue closed in layers.

Description of Post-Service Work:
Apply dressing, insure patient stability. Dictate op note, write post-op orders. Discuss the procedure outcome with the family, nurses, and other physicians. Order labs and medications. Carefully monitor patient's in hospital progress and chart progress notes, answer nurse, staff, and family questions. Discharge patient, provide post-op wound care management, activity, dietary, and medication instructions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008					
Presenter(s):	Kirk Kanter, MD and John Mayer, MD					
Specialty(s):	STS, AATS					
CPT Code:	33782					
Sample Size:	103	**Resp N:**	40	**Response:** 38.8 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	1.00	5.00
Survey RVW:	43.00	58.00	**60.00**	60.00	80.00
Pre-Service Evaluation Time:			**75.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	150.00	240.00	**300.00**	300.00	600.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**140.00**	99291x **2.00** 99292x **0.00**
Other Hospital time/visit(s):	**225.00**	99231x **1.00** 99232x **1.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**40.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33782	**Recommended Physician Work RVU: 60.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**300.00**		

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**140.00**	99291x **2.00** 99292x **0.00**
Other Hospital time/visit(s):	**225.00**	99231x **1.00** 99232x **1.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**40.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33413	090	59.74	**RUC Time**

CPT Descriptor Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33863	090	58.71	**RUC Time**	1,739

CPT Descriptor 1 Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 77.5 %

TIME ESTIMATES (Median)	**CPT Code: 33782**	**Key Reference CPT Code: 33413**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	95.00	
Median Intra-Service Time	300.00	297.00	
Median Immediate Post-service Time	60.00	40.00	
Median Critical Care Time	140.0	140.00	
Median Other Hospital Visit Time	225.0	225.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	40.0	63.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**866.00**	**898.00**	

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	4.58	4.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.58	4.29
Urgency of medical decision making	3.35	3.32

Technical Skill/Physical Effort (Mean)

Technical skill required	4.94	4.74
Physical effort required	4.71	4.65

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.84	4.61
Outcome depends on the skill and judgment of physician	5.00	4.77
Estimated risk of malpractice suit with poor outcome	3.65	3.61

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	5.00	4.00
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	4.00	4.00

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.*

SERVICES REPORTED WITH MULTIPLE 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) 33413 and 33681 or 33413 and 33412 or 33771-22 if coronary artery buttons are re-implanted 33780

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? 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. Based on the number of cases reported in the STS database

Specialty cardiothoracic surgery Frequency 50 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? 0
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is a congenital cardiac procedure, so it will rarely if ever be performed on Medicare Patients

Specialty cardiothoracic surgery Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

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:33783 Tracking Number B2 Specialty Society Recommended RVU: **65.00**

Global Period: 090 RUC Recommended RVU: **65.00**

CPT Descriptor: Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 12-month-old girl was born with mild cyanosis and a heart murmur. Echocardiography at birth revealed transposition of the great arteries (discordant ventricular-arterial connections) with ventricular septal defect and left ventricular outflow tract obstruction. The child's oxygen saturation on room air was 90% at birth and remained between 80% and 90% throughout the first year of life. At 12 months of age, the oxygen saturation started to fall to the 70% to 80% range. The child was referred for surgical intervention secondary to falling oxygen saturation levels.

The child's clinical and echocardiographic data was reviewed at Joint Cardiology and Cardiac Surgery Conference and the decision was made to proceed with a Nikaidoh procedure (Aortic root translocation over left ventricle). In the operating theatre, the surgeon identified a pattern of coronary artery branching necessitating individual transfer of the coronary arteries, with coronary artery button re-implantation after suitable coronary artery mobilization.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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

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

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

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

Description of Pre-Service Work:
Write preoperatve orders, review pertinent clinical information. Talk with family and coordinate with facilty and other physicians. Wait for induction of anesthesia and insertion of lines. Position patient. Scrub and gown, prep and drape

Description of Intra-Service Work: Under general endotracheal anesthesia, in the supine position, the patient is prepped and draped in standard aseptic fashion. Skin incision made via standard median sternotomy. Sternum is divided in the midline. Cardiac cannulae placed. Cardiopulmonary bypass initiated. Snares are snugged down on the caval cannulae allowing for complete heart bypass. The aorta is mobilized as are the proximal coronary arteries. The aorta is crossclamped and cold cardioplegic solution is injected into the aortic root. The ascending aorta is divided just below the crossclamp. The coronary ostia are excised from the aortic root with an oval of aortic tissue and mobilized. The aortic root is dissected off the right ventricle. The pulmonary artery is opened longitudinally with the incision carried dov across the pulmonary annulus to the VSD thus creating unobstructed left ventricular outflow. Septal muscle is excised a necessary. The aortic root is now translocated posteriorly with the back wall sewn to the remnant of the pulmonary valve annulus. A patch is used to close the VSD which superiorly attaches to the anterior wall of the proximal aortic root thus providing unobstructed flow from the LV to the aorta. The previously excised coronary buttons are transferred back to the translocated aortic root either using the original coronary button harvest sites in the aortic root or creating new

defects for transfer and closing the original harvest sites. The pulmonary bifurcation is widely mobilized and brought anterior to the distal ascending aorta (the LeCompte maneuver). An end-to-end anastomosis is performed between the proximal ascending aorta and the distal ascending aorta. Right ventricular to pulmonary artery continuity is established either with a valved conduit or by attaching the posterior wall of the main pulmonary artery remnant to the right ventricle and roofing it with a non-valved patch. Air is evacuated from the cardiac chambers and the crossclamp is released. After satisfactory rewarming and resuscitation, the child is then weaned from cardiopulmonary bypass. The cannulae are removed and the sites secured. Chest tubes and temporary pacing wires are placed. The sternum is closed with wires, the abdominal fascia, skin and subcutaneous tissue closed in layers.

Description of Post-Service Work:
Apply dressing, insure patient stability. Dictate op note, write post-op orders. Discuss the procedure outcome with the family, nurses, and other physicians. Order labs and medications. Carefully monitor patient's in hospital progress and chart progress notes, answer nurse, staff, and family questions. Discharge patient, provide post-op wound care management, activity, dietary, and medication instructions.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008				
Presenter(s):	Kirk Kanter, MD and John Mayer, MD				
Specialty(s):	STS, AATS				
CPT Code:	33783				
Sample Size:	103	**Resp N:**	40	**Response:** 38.8 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	1.00	6.00
Survey RVW:	48.00	60.00	**61.00**	65.00	86.60
Pre-Service Evaluation Time:			**75.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	150.00	280.00	**300.00**	360.00	600.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**140.00**	99291x **2.00** 99292x **0.00**
Other Hospital time/visit(s):	**225.00**	99231x **1.00** 99232x **1.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**40.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33783	**Recommended Physician Work RVU: 65.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**360.00**		

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**140.00**	99291x **2.00** 99292x **0.00**
Other Hospital time/visit(s):	**225.00**	99231x **1.00** 99232x **1.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**40.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33413	090	59.74	**RUC Time**

CPT Descriptor Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33863	090	58.71	**RUC Time**	1,739

CPT Descriptor 1 Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 30 **% of respondents:** 75.0 %

TIME ESTIMATES (Median)	CPT Code: 33783	Key Reference CPT Code: 33413	Source of Time RUC Time
Median Pre-Service Time	63.00	95.00	
Median Intra-Service Time	360.00	297.00	
Median Immediate Post-service Time	60.00	40.00	
Median Critical Care Time	140.0	140.00	
Median Other Hospital Visit Time	225.0	225.00	
Iedian Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	40.0	63.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**926.00**	**898.00**	
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	4.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.20
Urgency of medical decision making	3.42	3.36

Technical Skill/Physical Effort (Mean)

Technical skill required	4.94	4.75
Physical effort required	4.72	4.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.94	4.64
Outcome depends on the skill and judgment of physician	5.00	4.78
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	4.00	4.00
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	4.00	4.00

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 expert panel reviewed the data and felt that the 75th percentile was more representative of the differential of work for the coronary reimplantation than the 50th percentile and that this was not correctly represented in the data. The expert panel feels that this is primarily because physicians typically perform only one procedure or the other. In addition, the expert panel felt that the both 3377X1 and 3377X2 are more difficult procedures than the reference code, 33413. The 50th percentile for the 3377X1 represents this difference and the 75th percentile for 3377X2 represents this differece from

33413 and the additional work of coronary reimplantation. The 75th percentile was used for both the time and the work RVU for 3377X2.

SERVICES REPORTED WITH MULTIPLE 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) 33413 and 33681 or 33413 and 33412 or 33771-22 if coronary artery buttons are re-implanted 33780

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? 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. Based on the number of cases reported in the STS database

Specialty cardiothoracic surgery Frequency 50 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? 1
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. This is a congenital cardiac procedure, so it will rarely if ever be performed on Medicare Patients

Specialty cardiothoracic surgery Frequency 1 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)

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. 33980 because it is more similar in value

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

CPT Code:_____

Specialty Society('s)_____

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

CPT Long Descriptor:

Sample Size: 103 Response Rate: (%): 38.8% Global Period: 090

Geographic Practice Setting %: Rural 0% Suburban 17% Urban 83%

Type of Practice %: 0% Solo Practice
12% Single Specialty Group
5% Multispecialty Group
83% 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 Committee consists of congenital and adult cardiac surgeons from around the country.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff fills out the pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility. They will also coordinate with anesthesia, the pediatric cardiologist, the OR, and the intensive care unit to ensure space. The clinical staff will educate the patient's parents on what they need to do to prepare the child for surgery prior to the procedure. The clinical staff will also help coordinate parental accommodations if necessary. The clinical staff will also call in any prescriptions necessary for the patient.

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities

The clinical staff will help coordinate the discharge of the patient from the hospital.

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**33782**	**33783**
2	**Meeting Date: October 2008**	**CMS**	**Staff**	**Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation**	**Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia**
3	**LOCATION**	**Code**	**Type**	**Facility**	**Facility**
4	**GLOBAL PERIOD**				
5	**TOTAL CLINICAL LABOR TIME**	**L051A**	**RN**	**125.0**	**125.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**60.0**	**60.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L051A**	**RN**	**12.0**	**12.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**53.0**	**53.0**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	**L051A**	**RN**	5	5
12	Coordinate pre-surgery services	**L051A**	**RN**	20	20
13	Schedule space and equipment in facility	**L051A**	**RN**	8	8
14	Provide pre-service education/obtain consent	**L051A**	**RN**	20	20
15	Follow-up phone calls & prescriptions	**L051A**	**RN**	7	7
16	**End: When patient enters office/facility for surgery/procedure**				
17	**SERVICE PERIOD**				
18	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
19	Review charts				
20	Greet patient and provide gowning				
21	Obtain vital signs				
22	Provide pre-service education/obtain consent				
23	Prepare room, equipment, supplies				
24	Setup scope (non facility setting only)				
25	Prepare and position patient/ monitor patient/ set up IV				
26	Sedate/apply anesthesia				
27	**Intra-service**				
28	Assist physician in performing procedure				
29	**Post-Service**				
30	Monitor pt. following service/check tubes, monitors, drains				
31	Clean room/equipment by physician staff				
32	Clean Scope				
33	Clean Surgical Instrument Package				
34	Complete diagnostic forms, lab & X-ray requisitions				
35	Review/read X-ray, lab, and pathology reports				
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
37	Discharge day management	**L051A**	RN	**12**	12
38	Other Clinical Activity (please specify)				
39	**End: Patient leaves office**				
40	**POST-SERVICE PERIOD**				
41	**Start: Patient leaves office/facility**				
42	Conduct phone calls/call in prescriptions				
43	*List Number and Level of Office Visits*				
44	99211 16 minutes		16		
45	99212 27 minutes		27		
46	99213 36 minutes		36		
47	99214 53 minutes		53	**1**	1
48	99215 63 minutes		63		
49	Other				
50	*Total Office Visit Time*			**53**	**53**
51	Other Activity (please specify)				
52	**End: with last office visit before end of global period**				
53	**MEDICAL SUPPLIES**		Unit		
54	pack, minimum multi-specialty visit	SA048	pack	**1**	1
55	pack, post-op incision care (suture & staple)	SA053	pack	**1**	1
56	**EQUIPMENT**				
57	table, power	EF031		**53**	53
58	light, exam	EQ168		**53**	53

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Ventricular Assist Devices

In February 2009, the CPT Editorial Panel created three new codes to describe the replacement of ventricular assist devices (VAD). With the transition of VADs to longer term uses, it has become necessary to replace the VAD pump for mechanical failure or embolization. The three new codes describe the removal and replacement of intracorporeal and extracorporeal of VADs.

33981

The specialty society requested that code 33981 *Replacement of extracorporeal ventricular assist device, single or biventricular pump(s); single or each pump* be contractor priced. The specialty society determined that the work RVU from the survey results were not representative of the work involved in this procedure. The specialty society believes that the code and vignette are representative for the procedure, but that the survey respondents took extra work/factors outside the pump replacement descriptor for the code into account when valuing the procedure (such as cannula replacement). The specialty society determined that the procedure will be properly valued if it is surveyed with the entire family of codes. The specialty society plans to submit the rest of the family of VAD codes to CPT for review at the October 2009 meeting. **The RUC agrees with the specialty society and recommends that code 33981 be contractor priced.**

33982, 33983

The RUC reviewed codes 33982 *Replacement of ventricular assist device; implantable intracorporeal, single ventricle, without cardiopulmonary bypass* and 33983 *Replacement of ventricular assist device; implantable intracorporeal, single ventricle, with cardiopulmonary bypass* and had a thorough discussion regarding the specialty survey results for these two services. The RUC determined that the low performance rate of these services, low survey response rate and other typical methods of valuation (references codes/building block) rendered inappropriate work RVUs for these services. **Therefore, the RUC recommends that codes 33982 and 33983 be contractor priced.** The specialty society indicated that they intend to review the entire family of VAD codes to determine the next steps. The VAD replacement codes will be valued with the new VAD code family or as part of the 5-year review with identified VAD codes if appropriate.

93750

The RUC reviewed code 93750 *Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report* and agreed with the specialty society that 93750 is comparable to 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)* (work RVU = 0.92). However, the RUC noted that the reference service is a ZZZ global, whereas the surveyed code is a XXX global. The survey respondents indicated that 93750 does not require any pre-service or post-service time, making it similar to a ZZZ global code. As such, the RUC determined that 93750 is very similar to the reference service 95973. In addition, the two codes require identical intra-service time of 30 minutes. Therefore, the RUC agreed that the physician work and time required to perform both services is identical. **The RUC recommends a physician work RVU of 0.92 for code 93750.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs for code 93750 as recommended by the specialty society.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
The insertion of a ventricular assist device (VAD) can be performed via percutaneous (0048T) or transthoracic (33975, 33976, 33979) approach. The location of the VAD may be intracorporeal or extracorporeal. Removal of a VAD (33977, 33978, 33980, 0050T) includes removal of the entire device, including the cannulas. Replacement of a VAD pump includes the removal of the pump and insertion of a new pump, connection, de-airing, and initiation of the new pump. Replacement of the entire device, i.e.pump(s) and cannulas, is reported using the insertion codes. Do not also report removal. (For percutaneous implantation of extracorporeal ventricular assist device or for removal of percutaneously implanted extracorporeal ventricular assist device, see Category III codes 0048T, 0050T. For replacement of a percutaneously placed extracorporeal ventricular assist device, use 33999)				
•33981	V1	Replacement of extracorporeal ventricular assist device, single or biventricular pump(s); single or each pump	XXX	Contractor Price

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●33982	V2	Replacement of ventricular assist device; implantable intracorporeal, single ventricle, without cardiopulmonary bypass	XXX	Contractor Price
●33983	V3	implantable intracorporeal, single ventricle, with cardiopulmonary bypass	XXX	Contractor Price
●93750	V4	Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report (Do not report 93750 in conjunction with 33975, 33976, 33979, 33981-33983)	XXX	0.92
0050T		*Removal of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation* (For replacement of a ventricular assist device, extracorporeal, percutaneous transseptal access, use 33999)		N/A

148

March 31, 2009

Dear Dr. Rich,

Re: Recommendations for code 33981 - Replacement of extracorporeal ventricular assist device, single or biventricular pump(s); single or each pump

The STS would like to request that new code 33981 - be carrier priced for 2010. The Society feels that the value from the survey results is not representative of the work involved in this procedure.

The original code proposal that the STS developed was more comprehensive and included several additional codes. However, due to various reasons, the STS ended up separating out the 4 new codes from the rest of the proposal. The STS believes that the code and vignette are representative for the procedure, but that the members surveyed took extra work/factors outside the pump replacement descriptor for the code into account when valuing the procedure (such as cannula replacement). The STS feels that the procedure will be properly valued if it is surveyed with the entire family of codes. The STS plans to submit the rest of the family of VAD codes to CPT for review at the October meeting.

Sincerely,

Jim Levett, MD

STS/AATS RUC Advisor.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33981 Tracking Number V1 Specialty Society Recommended RVU: **CP**

Global Period: XXX RUC Recommended RVU: **CP**

CPT Descriptor: Replacement of extracorporeal ventricular assist device, single or biventricular pump(s); single or each pump

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old patient with life-limiting ventricular dysfunction presents with mechanical failure of his ventricular assist device. He is scheduled for device pump replacement.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 100%

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

Description of Pre-Service Work:

Description of Intra-Service Work: Inflow and outflow cannulas are clamped, and the assist device pump is removed and inspected. A new ventricular assist device pump is physically connected to the inflow and outflow cannulas. The pump is primed and de-aired to prevent gas embolization. The device is activated to support the circulation, and its flow characteristics varied to ensure that adequate flow rates are achievable, and that there is unobstructed inflow and outflow. During the process of VAD initiation, the patient's intravascular volume and vasoactive drug therapy are adjusted to achieve satisfactory, stable cardiovascular function and end-organ perfusion.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	Joseph Cleveland, MD; Keith Naunheim, MD		
Specialty(s):	cardiothoracic surgery		
CPT Code:	33981		
Sample Size:	33	**Resp N:** 10	**Response:** 30.3 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**4.00**	9.00	10.00
Survey RVW:	3.00	25.00	**30.00**	30.00	45.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	90.00	180.00	**240.00**	240.00	300.00

Immediate Post Service-Time:	**120.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33981	**Recommended Physician Work RVU: 0.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**120.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33975	XXX	20.97	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, single ventricle

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33976	XXX	22.70	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33981**	**Key Reference CPT Code: 33975**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	120.00	
Median Intra-Service Time	240.00	330.00	
Median Immediate Post-service Time	120.00	180.00	
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	**423.00**	**630.00**	
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	4.80	4.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.40
Urgency of medical decision making	4.80	4.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	4.20
Physical effort required	2.20	4.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4.60
Outcome depends on the skill and judgment of physician	4.80	4.60
Estimated risk of malpractice suit with poor outcome	4.00	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.40	4.40
Intra-Service intensity/complexity	4.40	4.40
Post-Service intensity/complexity	4.60	4.60

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 STS would like to request that this code be carrier priced for 2010. The society feels that this value is not representative of the work involved in this procedure. This was originally part of a bigger code set and the STS feels that it would be more properly valued if we submit the rest of the family of codes to CPT and then value this code with the new family of codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999

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? 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 cardiothoracic surgery 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 cardiothoracic 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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33982 Tracking Number V2 Specialty Society Recommended RVU: **50**

Global Period: XXX RUC Recommended RVU: **CP**

CPT Descriptor: Replacement of ventricular assist device; implantable intracorporeal, single ventricle, without cardiopulmonary bypass

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old patient with life-limiting ventricular dysfunction presents with mechanical failure of his ventricular assist device. He is scheduled for device pump replacement.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 100%

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

Description of Pre-Service Work: Review the surgical procedure including the pre-operative work-up, review of periopeative durgs, and prophylaxix against deep vein thrombosis/pulmonay embolism. Change into scrub clothes, check with lab on availability of blood and/or cross match, check that necessary surgical instruments, supplies,and devices are available in the OR. Coordinate care with the OR team, including anesthesia, nursing, physician assistants, and pump technicians, prepare for the need to go on cardiopulmonary bypass urgently if needed. Supervise setup of bypass equipment. Review planned procedure and positioning and draping of patient. Position patient, scrub and gown.

Description of Intra-Service Work: A reoperative median sternotomy is performed and the patient if fully anticoagulated. The implanted ventricular assist device is dissected free from surrounding scar tissue, avoiding injury to vital structures. The dissection is extended to permit ready access to the great vessels and the right heart for urgent cannulation to institute cardiopulmonary bypass should it be necessary. VAD flow rates are gradually reduced, and the patient carefully weaned from its assistance with adjustment of intravascular volume and inotropic agents. Inflow and outflow cannulas are clamped, and the assist device pump is removed and inspected. A new ventricular assist device is physically onnected to the inflow and outflow cannulas. The device is primed and de-aired to prevent gas embolization. The evice pump is activated to support the circulation, and its flow characteristics varied to ensure that adequate flow rates are achievable, and that there is unobstructed inflow and outflow. During the process of VAD initiation, the patients

Description of Post-Service Work: Apply dressing, manage postop medications, manage fluid and monitor ventilatory support and other non-cardica subsystems and use of blood products. Monitor for post op bleeding, heart failure, and

coagulopathic events. Discuss procedure outcome with patient family and other coordinating physicians. Write post-op orders and dictate report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Joseph Cleveland, MD; Keith Naunheim, MD				
Specialty(s):	cardiothoracic surgery				
CPT Code:	33982				
Sample Size:	33	**Resp N:**	10	**Response:** 30.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.50**	4.25	10.00
Survey RVW:	4.00	36.25	**50.00**	55.00	80.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	195.00	**330.00**	360.00	500.00

Immediate Post Service-Time:	**120.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33982	**Recommended Physician Work RVU: 50.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**330.00**		

Immediate Post Service-Time:	**120.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	XXX	45.93	**RUC Time**

CPT Descriptor Insertion of ventricular assist device, implantable intracorporeal, single ventricle

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33975	XXX	20.97	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, single ventricle

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 80.0 %

TIME ESTIMATES (Median)

	CPT Code: 33982	**Key Reference CPT Code: 33979**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	52.50	
Median Intra-Service Time	330.00	410.00	
Median Immediate Post-service Time	120.00	150.00	
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	**513.00**	**612.50**	
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	4.88	4.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.88
Urgency of medical decision making	5.00	4.88

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.75
Physical effort required	5.00	4.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.88
Outcome depends on the skill and judgment of physician	5.00	4.88
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.75	4.63
Intra-Service intensity/complexity	5.00	4.88
Post-Service intensity/complexity	5.00	4.88

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) 33999

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? 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.

Specialty cardiothoracic surgery Frequency 50 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.

Specialty cardiothoracic surgery 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

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:33983 Tracking Number V3 Specialty Society Recommended RVU: **50**

Global Period: XXX RUC Recommended RVU: **CP**

CPT Descriptor: Replacement of ventricular assist device; implantable intracorporeal, single ventricle, with cardiopulmonary bypass

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old patient with life-limiting ventricular dysfunction presents with mechanical failure of his ventricular assist device. He is scheduled for device pump replacement.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 100%

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

Description of Pre-Service Work: Review the surgical procedure including the pre-operative work-up, review of periopeative durgs, and prophylaxix against deep vein thrombosis/pulmonay embolism. Change into scrub clothes, check with lab on availability of blood and/or cross match, check that necessary surgical instruments, supplies,and devices are available in the OR. Coordinate care with the OR team, including anesthesia, nursing, physician assistants, and pump technicians. Supervise setup of bypass equipment. Review planned procedure and positioning and draping of patient. Position patient, scrub and gown.

Description of Intra-Service Work: A reoperative median sternotomy is performed and the patient if fully anticoagulated. The implanted ventricular assist device is dissected free from surrounding scar tissue, avoiding injury to vital structures. The dissection is extended to permit ready access to the great vessels and the right heart. The patient does not tolerate weaning from the VAD, and is therefore cannulated for cardiopulmonary bypass. This is initiated, the inflow and outflow VAD cannulas are clamped, and the assist device is removed and inspected. A new ventricular assist device pump is physically connected to the inflow and outflow cannulas. The pump is primed and de-aired to prevent gas embolization. The device is activated to support the circulation, and its flow characteristics varied to ensure that adequat flow rates are achievable, and that there is unobstructed inflow and outflow. During the process of VAD initiation, the patients intravascular volume and vasoactive drug therapy are adjusted to achieve satisfactory, stable cardiovascular function and end-organ perfusion. Hemostasis is achieved and the sternotomy closed over drains.

Description of Post-Service Work:

Apply dressing, manage postop medications, manage fluid and monitor ventilatory support and other non-cardica subsystems and use of blood products. Monitor for post op bleeding, heart failure, and coagulopathic events. Discuss procedure outcome with patient family and other coordinating physicians. Write post-op orders and dictate report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Joseph Cleveland, MD; Keith Naunheim, MD				
Specialty(s):	cardiothoracic surgery				
CPT Code:	33983				
Sample Size:	33	**Resp N:**	10	**Response:** 30.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	8.00	10.00
Survey RVW:	4.00	40.00	**50.00**	54.75	80.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**25.00**		
Intra-Service Time:	120.00	240.00	**360.00**	360.00	500.00

Immediate Post Service-Time:	**120.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33983	**Recommended Physician Work RVU: 50.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**360.00**		

Immediate Post Service-Time:	**120.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	XXX	45.93	RUC Time

CPT Descriptor Insertion of ventricular assist device, implantable intracorporeal, single ventricle

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33976	XXX	22.97	RUC Time

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 80.0 %

TIME ESTIMATES (Median)	CPT Code: 33983	Key Reference CPT Code: 33979	Source of Time RUC Time
Median Pre-Service Time	63.00	120.00	
Median Intra-Service Time	360.00	360.00	
Median Immediate Post-service Time	120.00	200.00	
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	**543.00**	**680.00**	
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	4.89	4.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.89
Urgency of medical decision making	5.00	4.89

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.89
Physical effort required	4.89	4.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.89
Outcome depends on the skill and judgment of physician	5.00	4.89
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.78	4.67
Intra-Service intensity/complexity	4.89	4.22
Post-Service intensity/complexity	5.00	4.89

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) 33999

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? 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.

Specialty cardiothoracic surgery Frequency 50 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.

Specialty cardiothoracic surgery Frequency 50 Percentage 100.00 %

pecialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? 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:93750 Tracking Number V4 Specialty Society Recommended RVU: **1.75**

Global Period: XXX RUC Recommended RVU: **0.92**

CPT Descriptor: Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report
(Do not report 93750 in conjunction with 33975, 33976, 33979, 33981-33983)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old patient is seen for regular, scheduled ventricular assist device follow-up assessment (E/M reported separately). The VAD is interrogated.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 65%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

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

Description of Pre-Service Work:

Description of Intra-Service Work: The physician disconnects the patient from their battery and attaches the outflow conduit to a cable which in turn is connected to a non-portable VAD Systems Monitor which downloads information from the patient's VAD and performs a series of diagnostic checks (i.e., VAD stroke rate, flow volume, pump rate, alarm history) to ensure the VAD is functioning within specified parameters. This real-time data is compared to recorded data to determine functioning as well as patient compliance with VAD operating instructions when the patient is engaged in activities of daily living.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Joseph Cleveland, MD; Mihai Gheorghiade, MD; Keith Naunheim, MD				
Specialty(s):	cardiothoraic surgery, cardiology				
CPT Code:	93750				
Sample Size:	67	**Resp N:**	20	**Response:** 29.8 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**40.00**	67.50	300.00
Survey RVW:	0.95	1.75	**2.50**	4.00	9.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	0.00	20.00	**30.00**	210.00	480.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	93750	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99233	XXX	2.00	**RUC Time**

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99478	XXX	2.75	**RUC Time**	10

CPT Descriptor 1 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.30	**RUC Time**	3,254,499

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of 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
93289	XXX	0.78	**RUC Time**

CPT Descriptor Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 45.0 %

TIME ESTIMATES (Median)	CPT Code: 93750	Key Reference CPT Code: 99233	Source of Time RUC Time
Median Pre-Service Time	0.00	10.00	
Median Intra-Service Time	30.00	30.00	

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	**30.00**	**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	4.44	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.44
Urgency of medical decision making	4.22	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	3.44
Physical effort required	3.78	3.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.78	3.33
Outcome depends on the skill and judgment of physician	4.78	3.33
Estimated risk of malpractice suit with poor outcome	4.11	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.89	2.11
Intra-Service intensity/complexity	3.56	2.56
Post-Service intensity/complexity	4.00	3.11

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 cardiothoracic surgeon and the cardiologists both follow the patient after VAD insertion. The typical pattern of care for a patient after discharge from the hospital in the outpatient setting for the first year post VAD insertion is as follows:

1st month – the patient is seen weekly for evaluation and VAD device interrogation and programming

2nd month – the patient is seen every other week for evaluation and VAD device interrogation and programming

Months 3 - 12 – the patient is seen monthly for evaluation and VAD device interrogation and programming

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SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) This procedure will be reported with an E/M service on the same day. The level and type of evaluation will vary by patient

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) 0

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? Rarely

Specialty cardiology How often? Rarely

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 cardiothoraic surgery Frequency 5000 Percentage 50.00 %

Specialty cardiology Frequency 5000 Percentage 50.00 %

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? 5,984 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. here are 500,000 heart failure patients each year. Of that number approximately 374 will receive a long-term VAD device (based on current RUC database numbers). For the patients who receive a long term VAD device, the typical patient will be seen for 16 visits during the year (see additional rationale below for typical patient visit pattern).

Specialty cardiothoraic surgery Frequency 2992 Percentage 50.00 %

Specialty cardiology Frequency 2992 Percentage 50.00 %

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. 93289 is a more appropriate crosswalk

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

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

CPT Long Descriptor:
93750 - Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

There is no pre-service clinical labor associated with this procedure. The clinical staff time for these activities would be captured under the E/M code which is reported separately

Intra-Service Clinical Labor Activities:
The clinical staff will prepare the equipment and the room for the interrogation and then will assist the physician with a portion of the interrogation procedure as necessary. The clinical staff will then clean the equipment and the room at the conclusion of the procedure.

Post-Service Clinical Labor Activities:

There is no post-service clinical labor associated with this procedure.

	A	B	C	D	E
1				93750	
2	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**				
5	**TOTAL CLINICAL LABOR TIME**			**17.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**17.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	**End: When patient enters office/facility for surgery/procedure**				
12	**SERVICE PERIOD**				
13	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
14	Prepare room, equipment, supplies	L051A	RN	**2**	
15	**Intra-service**				
16	Assist physician in performing procedure	L051A	RN	**12**	
17	**Post-Service**				
18	Clean room/equipment by physician staff	L051A	RN	**3**	
19	**End: Patient leaves office**				
20	**POST-SERVICE Period**				
21	**Start: Patient leaves office/facility**				
22	**End: with last office visit before end of global period**				
23	**MEDICAL SUPPLIES**		Unit		
24					
25	**Equipment**				
26	Exam Table	EF023		**30**	
27	Exam light	EQ168		**30**	
28	programmer, VAD			**30**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Pharyngeal Wall Resection with Flap

The CPT Editorial Panel at the February 2009 Meeting revised code 42894 *Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap, or free muscle, skin or fascial flap with microvascular anastamosis* to include identification of fasciocutaneus flaps as well as pedicled flaps and use of microvascular anastomosis and requested that the parenthetic note be reconciled with the language in the listed codes to direct the user to the appropriate codes. The RUC reviewed the current service description of 42894 as it contains the sentence: "The flap is sewn to the pharyngeal defect using interrupted sutures in two layers" to ensure there is no overlap in work between 42894 and the flap repair service. The RUC determined that there is no overlap in work between 42894 and the flap repair services (15732, 17534, 15757 or 15758) and indicated that these flap repair service should be reported separately as indicated in the parenthetical. **The RUC recommends that the aforementioned sentence be removed from the intra-service description for code 42894.**

180

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
▲42894	Y1	Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap, or free muscle, skin or fascial flap with microvascular anastamosis (For flap used for reconstruction, see codes 15732, 15734, 15756, 15757, or 15758)	090	33.61 (No Change)

RE: CPT Minutes February 2009 Meeting: Tab 20 Pharyngeal Wall Resection With Flap, proposed Editorial Change

Tab 20: Pharyngeal Wall Resection With Flap

This issue was presented by Joseph Leonard, MD and Richard Waguespack, MD of the American Academy of Otolaryngology- Head and Neck Surgery.

The Panel accepted Option B of this request to *editorially* revise code 42894 to include identification of fasciocutaneus flaps as well as pedicled flaps and use of microvascular anastomosis. The Panel requested that the parenthetic note be reconciled with the language in the listed codes to direct the user to the appropriate codes. The RUC will be asked to review the current service description as it contains the sentence: "The flap is sewn to the pharyngeal defect using interrupted sutures in two layers." This work is part of the flap repair service.

Surgery
Digestive System
Pharynx, Adenoids, and Tonsils
Excision, Destruction

▲42894 Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin or fascial flap ~~pedicled or~~ with microvascular anastamosis

(For flap used for reconstruction, ~~report~~ see codes 15732, 15734, 15756, 15757, or 15758)

Staff Note: After Panel review, Richard W. Waguespack, MD responded that 15757 was to remain in the instructional parenthetical. To reflect this information, the descriptor was revised to include a free skin flap to correlate with the listed flap codes.

It is the opinion of the American Academy of Otolaryngology- Head and Neck Surgery (AAOHNS) that there is no overlapping work between the just-revised resection code 42894 (CPT Editorial Panel's February 2009 meeting) and the series of flap closure codes with which it is to be reported. The change only specifies, and expands beyond myocutaneous, the types of currently-utilized and extensive flaps with which the resection is reconstructed. The existing intraservice work in the RUC database, reviewed in 2005, is as follows:

After tracheotomy is complete, a separate incision is outlined at level of the mid potion of the thyroid ala, curving posteriorly to the mastoid tip. A lazy "S" inferior extension is used if necessary. This incision is carried through the skin, subcutaneous tissues and platysma

muscle. Flaps are raised in the subplatysmal plane up to the mandible (care must also be taken to avoid injuring the marginal mandibular nerve along this dissection plane), down to the clavicle and back to the trapezius muscle. Care is taken not to connect this incision with the tracheotomy incision. [If necessary, a separately reportable ipsilateral neck dissection is completed including removal of the sternomastoid muscle.] The lip is split in the midline creating a Z-Plasty at the labiomental crease. The cheek flap is elevated back to the mental foramen. The first bicuspid tooth is removed. The mandibular periosteum is elevated on the inner and outer surface. A mandibular reconstruction plate is coapted to the mandible prior to osteotomy. The plate is then affixed to the mandible with transosteal screws. [Typically two separate plates are used for tooth-bearing mandibles; one larger plate and one tension band.] The plates and screws are then removed and set aside for use in closing the mandibulotomy. The mandible is divided using an oscillating saw. The lateral floor of mouth mucosa and the mylohyoid muscle are divided allowing the mandible to swing laterally. The submandibular gland is removed if not done previously. The position of the tumor, hypoglossal nerve and superior laryngeal nerve are confirmed. The blood supply to the tumor including facial vein, lingual and ascending pharyngeal arteries are ligated and divided as needed. With the tumor in direct view, the anterior pharyngeal and tongue base cuts are completed making sure to obtain an adequate tumor margin. While protecting the ascending carotid artery, the remaining cuts are completed, being careful to allow adequate margins of resection around the cancer. Frozen section margins are harvested. Orient resected specimen for the pathologist. Wound is irrigated and hemostasis assured while awaiting histologic assessment of margins. Review results of frozen section with the pathologist. Further resection of any involved margins is completed. Fresh surgical instruments are obtained. The surgeon changes gown and gloves to avoid contamination of the flap donor site with oral secretions or tumor. [Harvesting of a flap for reconstruction is performed as a separately reported procedure.] <u>The flap is sewn to the pharyngeal defect using interrupted sutures in two layers.</u> The neck wounds are copiously irrigated. The floor of mouth incisions are repaired. The mandibular reconstruction plate is fixed in position. The lip is reapproximated in two layers using a complex plastic closure of the vermillion border. A small caliber nasogastric feeding tube is placed. Closed suction drains are placed laterally in the wound and the wounds are closed using absorbable sutures for the platysma and staples for the skin. The endotracheal tube placed through the tracheotomy is exchanged for a cuffed tracheotomy tube and secured.

The reconstructive flap code **15732** intraservice work descriptor states the flap goes into an *intraoral* defect and no additional closure is needed. With the code we are revising (42894), closure of the defect associated with *pharyngeal* resection is not just suturing the flap into place. There are additional layers of tissue including lip, floor of mouth, skin, subcutaneous tissue, and mandibulotomy to be closed which are included in the resection code, not the flap code. Since 42894 was reviewed by the RUC in 2005 and 15732 is a myocutaneous flap (existing language for both codes) which can be used for a number of area reconstructions, any overlap of work between the resection and flap codes would be inconsequential and have been taken into consideration during the 2005 RUC deliberations.

15734 does not have a description of closure of or attachment to the resection site.

Also, intraservice work descriptors of **15756, 15757**, and **15758** do say, "The flap is then harvested, transferred to the recipient bed, *and loosely sewn in place*." This "loose sewing" is necessary to stabilize the flap for the microvascular anastomosis and does not constitute the final definitive operative site closure.

Thus, it is the AAOHNS's opinion that the changes to 42894 are strictly editorial and do not require survey of this code or any of those flap codes used for reconstruction. Thank you for your consideration and we remain,

Respectfully,

Joseph Leonard, MD
CPT Advisor, AAOHNS

Richard Waguespack, MD
Chair, CPT & Relative Value CMTE, AAOHNS

ADDENDA

Intraservice 15732 ***Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae):*** After the ablative part of the procedure has been completed, appropriate measurements of the defect are obtained and planning for the size of the flap is done. An incision is made over the ipsilateral temporalis muscle. Dissection is carried down to the temporal fascia, which is opened widely and the appropriate amount of muscle dissected from the temporal fossa. This muscle is then isolated on the deep temporal artery and its accompanying vein and the surrounding anatomic relationships assessed. A tunnel is created deep to the zygomatic arch with care not to disturb existing intact arteries and nerves. This tunnel is opened into the oral cavity and enlarged to accommodate the muscle flap. The flap is transposed and the vascular pedicle re-assessed. The flap is inset into the ***palatal*** defect and sutured in place. Because of its anatomic setting, no dressings are appropriate.

Intraservice 15734 ***Muscle, myocutaneous, or fasciocutaneous flap; trunk:*** After the ablative part of the procedure has been completed, appropriate measurements of the defect are obtained and planning for the size of the flap is done. An incision is made over the ipsilateral latissimus muscle. Dissection is carried down to the fascia, which is elevated off the muscle. The anterior and posterior borders of the muscle are exposed and the dissection continues inferiorly until enough length is obtained to reach the defect. The inferior portion of the muscle is then divided and the muscle elevated off the chest wall and isolated on the thoracodorsal vascular pedicle. A tunnel is created subcutaneously to reach the defect and enlarged to accommodate the muscle flap. The flap is transposed and the vascular pedicle re-assessed.

The flap is inset into the chest wall defect and sutured in place after placement of a closed suction drain. The donor site is closed primarily over suction drains. A split-thickness skin graft is harvested from the ipsilateral thigh, meshed and secured to the muscle. A bolster dressing is applied over the skin graft. The skin graft donor site is covered with an occlusive dressing.
Intraservice 15756 ***Free muscle or myocutaneous flap with microvascular anastomosis:*** The latissimus dorsi muscle without skin is harvested through a long posterolateral incision. If a muscle flap with skin is required, a skin paddle is outlined over the latissimus dorsi and the dissection is carried down to the latissimus dorsi muscle, taking care to attach the skin paddle to the latissimus dorsi fascia. Meticulous dissection is carried out to free the latissimus from the surrounding soft tissues and underlying muscles and chest wall. Once the pedicle is identified, microdissection to the vascular pedicle is completed. The flap is then harvested, **transferred to the recipient bed, and loosely sewn in place**. The operating microscope is then used to perform the microanastomosis of one artery and one or two veins using 9-0 or 10-0 suture. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The insetting of the flap is then meticulously completed. A drain is placed beneath the flap. Meticulous hemostasis of the donor site is achieved and the wound closed in layers of drains. A bulky dressing is applied to the recipient site and reinforced with plaster splint.

Intraservice 15757 ***Muscle Free skin flap with microvascular anastomosis:*** The skin flap is outlined on the posterolateral aspect of the thorax. The dissection is carried down the fascial layer of the underlying muscles. The flap is then elevated, taking care to protect the vascular supply to the flap. Once the pedicle is identified, microdissection of the vascular pedicle is completed. The flap is then harvested, **transferred to the recipient bed, and loosely sewn in place**. The operating microscope is then used to perform the microanastomosis of one artery and one or two veins using 9-0 or 10-0 suture. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. Drains are placed beneath the flap and the insetting of the flap is then meticulously completed. The donor site wound is closed in layers over drains and dressed. A bulky dressing is applied to the recipient site and reinforced with a plastic splint."

Intraservice 15758 ***Free fascial flap with microvascular anastomosis:*** An incision is made alone the lateral aspect of the arm and the subcutaneous tissue is carefully dissected down to the fascia. The fascia is then elevated off of the adjacent muscle down to the lateral intramuscular septum where the vessels are identified. Branches of the radial nerve are identified. The radial nerve is protected. The vascular pedicle is then carefully identified using microsurgical technique. Great care must be taken during the microvascular dissection so as to not injure the vessels. The flap is then harvested and **transferred to the recipient bed and loosely sewn in position.** Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The microanastomoses using the operating microscope of one artery and one or two veins is then carried out using 9-0 or 10-0 suture. The insetting of the flap is then meticulously completed. The donor site wound is closed in layers over the drains and sterile dressings are applied. A bulky dressing is applied to the recipient site and reinforced with plaster splint.

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
42892	Revision of pharyngeal walls	15.81	23.09	AHNS commented that the RVUs for the pharyngectomy procedures are Harvard-based and have never been reviewed by the RUC. AHNS believes that many other RUC reviewed procedures with similar time and visit patterns have significantly higher work RVUs and higher IWPUT values than the pharyngectomy codes.	The RUC agreed with the specialty's contention that there is compelling evidence that the previous Harvard evaluation mechanism or methodology was flawed. The original Harvard data is based on twelve otolaryngologists. Pre- and post-service data were not surveyed and this code was not part of the Harvard Phase 4 refinement. There was a lack of effort to compare work with intra-specialties or other specialties. Additionally, the patient population as also changed since 1995. Many patients today are either not candidates for chemo-radiation therapy because of advanced disease or have failed chemo-radiation therapy. The RUC recommends a work RVU of 23.09 above the median value do to size of the lesion and pharyngeal walls involved in this procedure. The RUC recommends the median survey times for code 42892. This procedure is typically performed with codes 38720, 38724, & 31600.	☑	1
42894	Revision of pharyngeal walls	22.85	30.00	AHNS commented that the RVUs for the pharyngectomy procedures are Harvard-based and have never been reviewed by the RUC. AHNS believes that many other RUC reviewed procedures with similar time and visit patterns have significantly higher work RVUs and higher IWPUT values than the pharyngectomy codes.	The RUC agreed that there is compelling evidence that the previous evaluation mechanism or methodology was flawed. The original Harvard data is based on twelve otolaryngologists. Pre- and post-service data were not surveyed and this code was not part of the Harvard Phase 4 refinement. There was a lack of effort to compare work with intra-specialties or other specialties. Additionally, the patient population as also changed since 1995. Many patients today are either not candidates for chemo-radiation therapy because of advanced disease or have failed chemo-radiation therapy. The RUC recommends the survey median work RVU of 30.00 and the median survey times for code 42894. This procedure is typically performed with codes 38720, 38724, 31600, 15734, & 43246.	☑	1

Action Key (1 = Adopt the recommended increase in the work RVU; 2 = Maintain the current work RVU; 3 = Adopt the recommended decrease in the work RVU; 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus; 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

Wrong SOR

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:42894 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **30.00**
RUC RVU: **30.00**

CPT Descriptor: Resection of pharyngeal wall requiring closure with myocutaneous flap

this SOR does not conform to ours & they modified it

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Resection of pharyngeal wall requiring closure with myocutaneous flap

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 medical history, endoscopy, pathology and radiology reports
- Review results of preadmission testing (lab, EKG, chest x-ray)
- Meet with patient and family to review planned procedure and post-operative management
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Obtain informed consent
- Review airway and medical management with anesthesiologist
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of patient - with placement of a transverse shoulder roll to provide neck extension.
- Make sure anesthesia monitoring equipment will not interfere with draping
- Review radiographic images on view box and review planned incisions and procedure – including reconstruction and dental continuity/integrity for planned mandibulotomy
- Outline areas of skin to be prepped and mark surgical incisions
- Scrub and gown
- Monitor/assist with prepping and draping – with care to protect the eyes
- Assist anesthesiologist in endotracheal intubation
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: After tracheotomy is complete, a separate incision is outlined at level of the mid potion of the thyroid ala, curving posteriorly to the mastoid tip. A lazy "S" inferior extension is used if necessary. This incision is carried through the skin, subcutaneous tissues and platysma muscle. Flaps are raised in the subplatysmal plane up to the mandible (care must also be taken to avoid injuring the marginal mandibular nerve along this dissection plane), down to the clavicle and back to the trapezius muscle. Care is taken not to connect this incision with the tracheotomy incision. [If necessary, a separately reportable ipsilateral neck dissection is completed including removal of the sternomastoid muscle.] The lip is split in the midline creating a Z-Plasty at the labiomental crease. The cheek flap is elevated back to the mental foramen. The first bicuspid tooth is removed. The mandibular periosteum is elevated on the inner and outer surface. A mandibular reconstruction plate is coapted to the mandible prior to osteotomy. The plate is then affixed to the mandible with transosteal screws. [Typically two separate plates are used for tooth-bearing mandibles; one larger plate and one tension band.] The plates and screws are then removed and set aside for use in closing the mandibulotomy. The mandible is divided using an oscillating saw. The lateral floor of mouth mucosa and the mylohyoid muscle are divided allowing the mandible to swing laterally. The submandibular gland is removed if not done previously. The position of the tumor, hypoglossal nerve and superior laryngeal nerve are confirmed. The blood supply to the tumor including facial vein, lingual and ascending pharyngeal arteries are ligated and divided as needed. With the tumor in direct view, the anterior pharyngeal and tongue base cuts are completed making sure to obtain an adequate tumor margin. While protecting the ascending carotid artery, the remaining cuts are completed, being careful

to allow adequate margins of resection around the cancer. Frozen section margins are harvested. Orient resected specimen for the pathologist. Wound is irrigated and hemostasis assured while awaiting histologic assessment of margins. Review results of frozen section with the pathologist. Further resection of any involved margins is completed. Fresh surgical instruments are obtained. The surgeon changes gown and gloves to avoid contamination of the flap dor site with oral secretions or tumor. [Harvesting of a flap for reconstruction is performed as a separately repor procedure.] The flap is sewn to the pharyngeal defect using interrupted sutures in two layers. The neck wounds are copiously irrigated. The floor of mouth incisions are repaired. The mandibular reconstruction plate is fixed in position. The lip is reapproximated in two layers using a complex plastic closure of the vermillion border. A small caliber nasogastric feeding tube is placed. Closed suction drains are placed laterally in the wound and the wounds are closed using absorbable sutures for the platysma and staples for the skin. The endotracheal tube placed through the tracheotomy is exchanged for a cuffed tracheotomy tube and secured.

Description of Post-Service Work: Post-service Hospital Work

- Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Check postoperative chest x-ray to confirm adequate placement of nasogastric feeding tube. Review immediate postoperative care with PACU/ICU staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Write postoperative note. Dictate operative report and copy the referring physician.
- Write orders for postoperative medications, diet, and patient activity
- Check wounds and monitor patient progress. Chart notes. Review patient management with nursing staff
- Check postoperative laboratory examination, including hematocrit and electrolytes, and adjust fluid replacement as indicated.
- Advance tube feedings as tolerated.
- Monitor closed suction drainage
- Tracheotomy tube is changed to uncuffed metal tube on when appropriate. [Trach tube is removed when patient can tolerate plugging of uncuffed metal tube]
- Manage dressings and monitor status of incision for signs of infection or fistula.
- Monitor pulmonary status by physical examination, periodic chest x-ray, if indicated, and by observing f postoperative fever or leukocytosis.
- Assure adequate level of pain control
- Discuss case with speech therapist
- Refer to physical therapist for shoulder rehab
- Review results of pathologic examination of surgical specimen and convey information to patient and family.
- Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy
- Write prescriptions for medications and supplies needed post-discharge.
- Home restrictions (ie, diet, activity, bathing) are discussed with the patient and family members.
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-service Office Work

- If trach tube not removed prior to discharge, examine site at dressing change. If trach removed prior to discharge, monitor healing of incision at site.
- Examine patient, remove sutures and staples
- Answer patient/family questions
- Order and review progress of speech and swallowing rehabilitation.
- Monitor diet caloric intake, arrange dietitian consultation if needed,
- Remove nasogastric feeding tube when patient is taking adequate oral intake.
- Post discharge labs/films are ordered and reviewed - begin routine surveillance for recurrent tumor
- Discuss the need for postoperative radiation with patient
- Arrange for postoperative radiation therapy consultation as needed. Discuss case with radiation oncologist and prepare documents for transmission to that office.
- Discuss dental consult
- Monitor healing of pharynx with indirect laryngoscopy or flexible fiberoptic laryngoscopy
- Monitor for malocclusion of dentition from the mandibulotomy, as well as possible mandibular nonunion
- Dictate progress notes for medical chart

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Wayne Koch, MD (AHNS) Drew Ridge, MD (AHNS) John Coleman, MD (AHNS) James Denneny, MD (AAO-HNS)				
Specialty(s):	American Head and Neck Society (AHNS) American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS)				
CPT Code:	42894				
Sample Size:	80	**Resp n:** 39		**Response:** 48.7 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	20.00	27.50	**30.00**	35.00	43.00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**20.0**		
Intra-Service Time:	160.00	240.00	**240.00**	345.00	480.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**40.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**218.0**	99231x **3.0** 99232x **4.0** 99233x **1.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**145.0**	99211x **0.0** 12x **1.0** 13x **4.0** 14x **1.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
43107	090	39.94

CPT Descriptor Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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
33405	090	34.95

CPT Descriptor 1 Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

MPC CPT Code 2	Global	Work RVU
15756	090	35.18

CPT Descriptor 2 Free muscle or myocutaneous flap with microvascular anastomosis

Other Reference CPT Code	Global	Work RVU
33426	090	32.95

CPT Descriptor Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 15.3 %

TIME ESTIMATES (Median)	**CPT Code: 42894**	**Key Reference CPT Code: 43107**
Median Pre-Service Time	95.00	90.00
Median Intra-Service Time	240.00	300.00
Median Immediate Post-service Time	40.00	45.00
Median Critical Care Time	0.0	120.00
Median Other Hospital Visit Time	218.0	207.00
Median Discharge Day Management Time	36.0	45.00
Median Office Visit Time	145.0	99.00
Median Total Time	~~774.00~~ 836	**906.00**
Other time if appropriate		

Total RVU

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	4.80	4.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	4.60
Urgency of medical decision making	4.80	4.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.80	4.60
Physical effort required	4.80	4.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	4.80
Outcome depends on the skill and judgment of physician	4.80	4.60
Estimated risk of malpractice suit with poor outcome	4.40	4.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.80	4.60
Intra-Service intensity/complexity	4.80	4.80
Post-Service intensity/complexity	4.80	4.80

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.*

'lease see attachment FOR FAMILY 4

SERVICES REPORTED WITH MULTIPLE 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. 38720, 38724, 31600, 15734 & 43246

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 38% No 62%

(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 3% I do not agree 97%
B. Patients requiring this service are now:
   more complex (more work) 93% less complex (less work) 0% no change 7%
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:

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:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
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:	
Number and Level of Office Visits:		99211:	
		99212:	
		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 oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
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:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Laparoscopic Paraesophageal Hernia Repair

In February 2009, the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) requested to defer RUC review of this issue until April 2009 after the CPT Editorial Panel clarifies SAGES' October 2008 request to develop two new codes instead of one code to describe laparoscopic paraesophageal hernia repair. The CPT Editorial Panel reviewed this issue at its February 2009 meeting and created two new codes to describe the laparoscopic approach to repair of paraesophageal and diaphragmatic hernias with and without implantation of mesh.

43281

The RUC reviewed code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* and compared it to key reference service 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU = 22.00, 80 minutes pre-time, 150 minutes intra-time and 30 minutes immediate post-time). The RUC reviewed the pre-service time and agreed with the specialty society that pre-service time package 4 – Facility Difficult patient/difficult procedure with some modifications was appropriate. The RUC agreed that an additional 12 minutes of positioning time was appropriate (15 minutes total positioning time) to reposition the patient from supine to modified lithotomy position after anesthesia is induced as well as adjust the operating room table and anesthesia lines so that the operative site is assessable for laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. The RUC also agreed to remove 5 minutes of scrub/dress/wait time (15 minutes total scrub/dress/wait time) as this was the median indicated by the survey respondents. The RUC determined that the intra-service time of 180 minutes and immediate post-service time of 30 minutes appropriately accounts for the physician time required to perform this service.

The RUC reviewed the survey intensity and complexity measures required for 43281 compared to key reference service 43279 and determined that 43281 is slightly more intense and complex. The specialty society indicated and the RUC agreed that the survey median work RVU of 26.50 appropriately accounts for the work required to perform this service. To provide additional support for this work RVU the specialty society indicated that code 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU = 29.24) was also cited by the survey respondents as a reference service. The intensity required to perform 43644 is similar to code 43281, further 43644 has the same intra-service time

but more post-operative work. If the additional 99232 visit and difference in office visits are subtracted the work RVUs for 43281 and 43644 is similar, 26.50 versus 26.85 respectively.

29.24 RVU for 43644
-1.39 one less 99232
-1.00 difference in office visit RVUs (2x99213 versus 1 each 99214, 99213, 99212
26.85

The RUC recommends the survey median work RVU of 26.50 for code 43281.

43282
The RUC reviewed code 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* and compared it to key reference service 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU = 29.24, 75 minutes pre-time, 180 minutes intra-time and 30 minutes immediate post-time). The RUC reviewed the pre-service time and agreed with the specialty society that pre-service time package 4 - Facility Difficult patient/difficult procedure with some modifications was appropriate. The RUC agreed that an additional 12 minutes of positioning time was appropriate (15 minutes total positioning time) to reposition the patient from supine to modified lithotomy position after anesthesia is induced as well as adjust the operating room table and anesthesia lines so that the operative site is assessable for laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. The RUC also agreed to remove 5 minutes of scrub/dress/wait time (15 minutes total scrub/dress/wait time) as this was the median indicated by the survey respondents. The RUC determined that the intra-service time of 210 minutes and immediate post-service time of 30 minutes appropriately accounts for the physician time required to perform this service. Code 43282 requires an additional 30 minutes of intra-service time compared to key reference service 43644 and other upper GI laparoscopic bariatric procedures to account for the additional time to dissect and remove the sac, consider important components of adequate repair, working high into the mediastinum along the esophagus in front of the aorta and in close proximity to the pleura and to sew the mesh.

The RUC reviewed the survey intensity and complexity measures required for 43282 compared to key reference service 43644 and determined that 43282 is slightly more intense and complex. The specialty society indicated and the RUC agreed that the survey median work RVU of 30.00 appropriately accounts for the work required to perform this service. Additionally, this recommendation, which is 3.50 work RVUs greater than 43281, accounts for the increased intra-operative time for mesh placement) and increased intensity for this more complex procedure. **The RUC recommends the survey median work RVU of 30.00 for 43282.**

New Technology
The RUC discussed how to ensure that 43281 and 43282 is not reported when repair of esophageal sliding hernia is performed. The specialty society indicated that they will address and provide correct coding education via a CPT Assistant article as well as the American College of Surgeons bulletin. The RUC recommends that codes 43281 and 43282 be placed on the new technology list to solely review the volume of these services in a couple years to ensure appropriate reporting..

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs for 43281 and 43282.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
43280		*Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)*	090	18.00 (No Change)
●43281	Z1	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	090	26.50
●43282	Z2	with implantation of mesh (For transthoracic paraesophageal hernia repair, see 39520. For transabdominal paraesophageal hernia repair, see 39502) (Do not report 43281, 43282 in conjunction with 43280, 43450, 43453, 43456, 43458, 49568)	090	30.00

196

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43281 Tracking Number Z1 Specialty Society Recommended RVU: **26.50**

Global Period: 090 RUC Recommended RVU: **26.50**

CPT Descriptor: Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old woman presents with dysphagia, reflux, and intermittent chest pain. A work-up including upper GI series, endoscopy, and CT scan of the chest and abdomen demonstrates a Type III paraesophageal hernia with greater than 50% of the stomach present in the chest. She undergoes laparoscopic repair without implantation of mesh

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 13% , Admitted (more than 24 hours) 87%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform a E&M service later on the same day 91%

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

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

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

Description of Pre-Service Work: Assure appropriate selection, timing, and administration of DVT prophylaxis. Determine indication for intra-operative antibiotics and prescribe as necessary. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports and pulmonary and cardiac co-morbidities. Reexamine patient to make sure that physical findings have not changed, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management. Discuss the possibility of mesh implantation to reinforce the hiatal repair. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment. Perform team checklist verification (anesthesia, OR staff, house staff). Assist in transfer of patient from gurney to operating table. Assist anesthesia team with line placement and induction of anesthesia and intubation. Monitor/assist with positioning of patient. 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 general anesthesia, surgical laparoscopy is performed. Pneumoperitoneum is established to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are sited through the anterior abdominal wall above the umbilicus. The viscera are inspected. An orogastric tube may be placed to

decompress the stomach if it will pass. The liver is retracted to allow visualization of the esophageal hiatus. The stomach is gently retracted into the abdomen to assess its degree of tethering in the thorax. The peritoneum overlying the right crus is incised and the plane along the hernia sac is developed. The dissection is extended anteriorly and laterally to the left crus. The base of the crural confluence is dissected free of adhesions to the sac. The hernia sac is carefully dissected into the mediastinum with caudal traction. The interfaces between the pleura, pericardium, spine and aorta are developed as the dissection is carried cephalad to the top of the hernia sac. The sac contents are completely reduced back into the abdominal cavity. The hernia sac is then excised taking care to avoid injury to stomach and vagal trunks. An esophageal dilator may be placed transorally. The esophagus is identified and dissected circumferentially and along its mediastinal course in order to reduce tension, allowing the gastroesophageal junction to rest comfortably within the abdominal cavity. Care is taken to identify and preserve the vagus nerves. The gastro-splenic ligament and the short gastric vessels are divided if necessary. The retro-esophageal window is developed and the esophagus is retracted caudally. The crural pillars are then approximated with sutures. Anterior reinforcement of the diaphragm is performed with sutures as needed, the tightness of the repair being gauged visually or by the presence of the bougie or other device. Partial or total fundoplasty is then performed with sutures. Additional sutures may be placed to attach the gastric fundus and/or body to the diaphragm. The operative field is carefully inspected to ensure hemostasis. Esophageal tubes are removed as per surgeon preference. The liver retractor and then trocars are removed. The wounds are closed.

Description of Post-Service Work:
Hospital:
Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. 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 including need for patient controlled analgesia and anti-emetics. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart and record. Dictate operative report and copy referring physician(s). Discontinue perioperative antibiotic therapy as appropriate. Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. Order x-rays (e.g. barium esophagram) as per routine Examine patient, including reviewing vital signs and respiratory status and confirming as necessary. Auscultate heart and lungs 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. Monitor and document patient progress. 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, x-rays, medications, diet, and patient activity. Chart patient progress notes, daily. Review available x-rays (if ordered) Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate. Discuss in detail dietary restrictions for the immediate post-operative period (e.g. liquid, mechanical soft or regular diets and their duration) Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (i.e., diet as above, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when there is return of bowel function, adequate nutritional intake, and pain is controlled with oral analgesics. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office:
Talk with and examine patient and assess ease of swallowing. Assess pulmonary function. Remove dressings, sutures, when appropriate. Review activity and restrictions. Monitor healing of incisions with appropriate physical examination Discuss advancement of diet with slow introduction of solid foods. Monitor dietary caloric intake by weight. Answer patient/family questions. Write prescriptions for medication and therapy, as necessary. Discuss progress with referring physician(s) (verbal and written). Dictate/type progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Michael Edye, MD, FACS; Christopher Senkowski, MD, FACS; Keith Naunheim, MD, FACS				
Specialty(s):	general surgery, thoracic surgery, laparoscopic surgery				
CPT Code:	43281				
Sample Size:	300	**Resp N:**	83	**Response:** 27.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**6.00**	10.00	80.00
Survey RVW:	18.00	24.00	**26.50**	30.00	42.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	90.00	120.00	**180.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	43281	**Recommended Physician Work RVU: 26.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
43279	090	22.00	RUC Time

CPT Descriptor Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 20.4 %

TIME ESTIMATES (Median)	CPT Code: 43281	Key Reference CPT Code: 43279	Source of Time RUC Time
Median Pre-Service Time	70.00	80.00	
Median Intra-Service Time	180.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
edian Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**424.00**	**404.00**	
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	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.88
Urgency of medical decision making	3.65	3.41

Technical Skill/Physical Effort (Mean)

Technical skill required	4.47	4.29
Physical effort required	3.88	3.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	4.00
Outcome depends on the skill and judgment of physician	4.35	4.24
Estimated risk of malpractice suit with poor outcome	3.94	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.88	3.88
Intra-Service intensity/complexity	4.24	4.06
Post-Service intensity/complexity	3.06	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.*

Comparison to key reference code: 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed*

New code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* has become widely used with long term follow-up. The existing code structure reflects an abdominal

via laparotomy approach and a thoracic via thoracotomy approach, but not the laparoscopic approach which we believe represent the majority of procedures for this condition. Patients undergoing this procedure are usually elderly and very commonly have cardiac and respiratory co-morbidities, are on anti-platelet agents or anti-coagulation, and require arterial lines and careful anesthetic monitoring. In comparison to the key reference code, pre- and post-work would be nearly dentical. Intra-operative time is 30 minutes greater for new code 43281.

Pre-Time: With respect to the pre-service time, we recommend package 4 (difficult patient / difficult procedure) with the following modifications:

- Evaluation: no change (40 min)
- Positioning: Add 13 minutes (total = 15 min). After induction of anesthesia in supine position, the patient is repositioned in modified lithotomy and the OR table and anesthesia lines are adjusted so that the operative site is assessable for laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. This total time of 15 minutes is less than what the consensus group believes to be representative of laparoscopic operations, however, this is the survey median.
- Scrub/Dress/Wait: Subtract 5 minutes (total = 15 min). Although pre-time package includes 20 minutes for this component of pre-time, the survey median is 15 minutes.

RVW Recommendation: The survey intensity and complexity measures for the survey code are slightly greater than the reference code. Additionally, the survey data indicate the new code will require 30 minutes more intra-operative time. **The consensus committee reviewing the survey data recommends an RVW of 26.50, which is the survey median RVU.** This results in an IWPUT that is slightly greater than the reference code – accounting for the increased intensity and complexity of this operation.

Additional support: Code 43644 was also sited as a reference by survey respondents. The intensity of this procedure is similar to new code 43281. This procedure has the same intra-op time but more post-op work. If you subtract the difference in post-op work, the result is 26.85 which is similar to the recommended value of 26.50.

'9.24	RVW for 43644
-1.39	1 less 99232
-1.00	difference in office visit RVWs (2x99213 versus 1 each 99214, 99213, 99212)
26.85	

SERVICES REPORTED WITH MULTIPLE 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)
43289 Unlisted laparoscopy procedure, esophagus
43280-22 Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)

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

Specialty general surgery How often? Sometimes

Specialty thoracic surgery How often? Sometimes

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 estimate.

Specialty general surgery Frequency 3600 Percentage 90.00 %

Specialty thoracic surgery Frequency 400 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? 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 estimate of percentage of all patients that will undergo laparoscopic repair without mesh.

Specialty general surgery Frequency 1100 Percentage 91.66 %

Specialty thoracic surgery Frequency 100 Percentage 8.33 %

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. 44204 Laparoscopy, surgical; colectomy, partial, with anastomosis. This laparoscopic code has the same intra-op time (180 min) and similar RVW (26.29)

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:43282 Tracking Number Z2 Specialty Society Recommended RVU: **30.00**

Global Period: 090 RUC Recommended RVU: **30.00**

CPT Descriptor: Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old woman with episodes of post-prandial chest pain and abdominal pain is found to have a large type III paraesophageal hernia with organo-axial volvulus. She undergoes laparoscopic repair, including implantation of mesh.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 12% , Admitted (more than 24 hours) 88%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

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

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

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

Description of Pre-Service Work: Assure appropriate selection, timing, and administration of DVT prophylaxis. Determine indication for intra-operative antibiotics and prescribe as necessary. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports and pulmonary and cardiac co-morbidities. Reexamine patient to make sure that physical findings have not changed, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management. Discuss the possibility of mesh implantation to reinforce the hiatal repair. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment. Perform team checklist verification (anesthesia, OR staff, house staff). Assist in transfer of patient from gurney to operating table. Assist anesthesia team with line placement and induction of anesthesia and intubation. Monitor/assist with positioning of patient. 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 general anesthesia, surgical laparoscopy is performed. Pneumoperitoneum is established to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation or venous return. Four to six trocar ports are sited through the anterior abdominal wall above the umbilicus. The viscera are inspected. An orogastric tube may be placed to decompress the stomach if it will pass. The liver is retracted to allow visualization of the esophageal hiatus. The

stomach is gently retracted into the abdomen to assess its degree of tethering in the thorax. The peritoneum overlying the right crus is incised and the plane along the hernia sac is developed. The dissection is extended anteriorly and laterally to the left crus. The base of the crural confluence is dissected free of adhesions to the sac. The hernia sac is carefully dissected into the mediastinum with caudal traction. The interfaces between the pleura, pericardium, spine and aorta a developed as the dissection is carried cephalad to the top of the hernia sac. The sac contents are completely reduc back into the abdominal cavity. The hernia sac is then excised taking care to avoid injury to stomach and vagal trunks. An esophageal dilator may be placed transorally. The esophagus is identified and dissected circumferentially and along its mediastinal course in order to reduce tension, allowing the gastroesophageal junction to rest comfortably within the abdominal cavity. Care is taken to identify and preserve the vagus nerves. The gastro-splenic ligament and the short gastric vessels are divided if necessary. The retro-esophageal window is developed and the esophagus is retracted caudally. If possible the crural pillars are approximated with sutures. Anterior reinforcement of the diaphragm is performed with sutures as needed, the tightness of the repair being gauged visually or by the presence of the bougie or other device. Determine if mesh reinforcement of the repair is necessary. A relaxing incision may be created in the diaphragm. A suitably sized, shaped and trimmed piece of synthetic or biologic mesh prosthesis is introduced into the abdomen, positioned appropriately in the hiatal region and fixed with stitches, tacks, staples or other devices. Partial or total fundoplasty is then performed with sutures. Additional sutures may be placed to attach the gastric fundus and/or body to the diaphragm. The operative field is carefully inspected to ensure hemostasis. Esophageal tubes are removed as per surgeon preference. The liver retractor and then trocars are removed. The wounds are closed.

Description of Post-Service Work:
Hospital:
Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. 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 including need for patient controlled analgesia and anti-emetics. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note, including the Catalogue and Lot number of the implanted mesh, and place in chart and record. Dictate operative report and copy referring physician(s). Discontinue perioperative antibiotic therapy : appropriate. Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. Order x-rays (e.g. barium esophagram) as per routine. Examine patient, including reviewing vital signs and respiratory status and confirming as necessary. Auscultate heart and lungs. 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. Monitor and document patient progress. 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, x-rays, medications, diet, and patient activity. Chart patient progress notes, daily. Review available x-rays (if ordered). Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate. Discuss in detail dietary restrictions for the immediate post-operative period (e.g. liquid, mechanical soft or regular diets and their duration). Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (i.e., diet as above, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when there is return of bowel function, adequate nutritional intake, and pain is controlled with oral analgesics. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office:
Talk with and examine patient and assess ease of swallowing. Assess pulmonary function. Remove dressings, sutures, when appropriate. Review activity and restrictions. Monitor healing of incisions with appropriate physical examination Discuss advancement of diet with slow introduction of solid foods. Monitor dietary caloric intake by weight. Answer patient/family questions. Write prescriptions for medication and therapy, as necessary. Discuss progress with referring physician(s) (verbal and written). Dictate/type progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009
Presenter(s):	Michael Edye, MD, FACS; Christopher Senkowski, MD, FACS; Keith Naunheim, MD, FACS
Specialty(s):	general surgery, thoracic surgery, laparoscopic surgery
CPT Code:	43282
Sample Size: 300	**Resp N:** 83 — **Response:** 27.6 %
Sample Type:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**5.00**	11.00	50.00
Survey RVW:	15.00	27.00	**30.00**	32.00	52.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	115.00	150.00	**210.00**	240.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	43282	**Recommended Physician Work RVU: 30.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**210.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
43644	090	29.24	RUC Time

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 21.6 %

TIME ESTIMATES (Median)	CPT Code: 43282	Key Reference CPT Code: 43644	Source of Time RUC Time
Median Pre-Service Time	70.00	75.00	
Median Intra-Service Time	210.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	79.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**454.00**	**502.00**	
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	4.06	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.06
Urgency of medical decision making	4.00	3.39

Technical Skill/Physical Effort (Mean)

Technical skill required	4.78	4.44
Physical effort required	4.44	4.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.17	3.94
Outcome depends on the skill and judgment of physician	4.56	4.33
Estimated risk of malpractice suit with poor outcome	3.83	3.94

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

Time Segments (Mean)

Pre-Service intensity/complexity	4.11	3.89
Intra-Service intensity/complexity	4.67	4.33
Post-Service intensity/complexity	3.44	3.61

Additional Rationale

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

Comparison to key reference code: 43644 Laparoscopy, *surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*

New code 432X2 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* has become widely used with long term follow-up. The existing code structure reflects an abdominal

via laparotomy approach and a thoracic via thoracotomy approach, but not the laparoscopic approach which we believe represent the majority of procedures for this condition. Patients undergoing this procedure are usually elderly and very commonly have cardiac and respiratory co-morbidities, are on anti-platelet agents or anti-coagulation, and require arterial lines and careful anesthetic monitoring. New code 43282 has similar intensity, but requires more intra-op time compared to the upper GI laparoscopic bariatric procedures. This includes dissection and removal of the sac, considered important components of adequate repair, requires working high into the mediastinum along the esophagus, just in front of the aorta and in close proximity to the pleura. Post-operative work is slightly greater for morbidly obese patients undergoing 43644 compared to code 43282.

Pre-Time: With respect to the pre-service time, we recommend package 4 (difficult patient / difficult procedure) with the following modifications:

- Evaluation: no change (40 min)
- Positioning: Add 13 minutes (total = 15 min). After induction of anesthesia in supine position, the patient is repositioned in modified lithotomy and the OR table and anesthesia lines are adjusted so that the operative site is assessable for laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. This total time of 15 minutes is less than what the consensus group believes to be representative of laparoscopic operations, however, this is the survey median.
- Scrub/Dress/Wait: Subtract 5 minutes (total = 15 min). Although pre-time package includes 20 minutes for this component of pre-time, the survey median is 15 minutes.

RVW Recommendation: The survey intensity and complexity measures for the survey code are slightly greater than the reference code. **The consensus committee reviewing the survey data recommends an RVW of 30.00, which is the survey median RVU.** This results in an IWPUT that is almost identical to the key reference code – accounting for the similar intensity and complexity of this operation and the differences in intra-time and post-op work. Additionally, this recommendation, which is 3.50 RVUs greater than 43281, accounts for the increased intra-operative time (for mesh placement) and increased intensity for this more complex 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)
43289 Unlisted laparoscopy procedure, esophagus

43280-22 Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)

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

Specialty general surgery How often? Sometimes

Specialty thoracic surgery How often? Sometimes

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 estimate.

Specialty general surgery Frequency 900 Percentage 90.00 %

Specialty thoracic surgery Frequency 100 Percentage 10.00 %

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. Specialty estimate of percentage of all patients that will undergo laparoscopic repair without mesh.

Specialty general surgery Frequency 720 Percentage 90.00 %

Specialty thoracic surgery Frequency 80 Percentage 10.00 %

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. Surgical

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

CPT Long Descriptor:

Z1	43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
Z2	43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh

Sample Size: **N/A**

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 committee of general surgeons and thoracic surgeons agree that these procedures would not be performed in an office setting and would not typically be emergent.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the facility to schedule space and equipment needed and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information including instructions on diet and changes to medications prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy with the PCP prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management and office visits related activities are performed.

	A	B	C	D	E	F	G
1				Z1		Z2	
2				43281		43282	
3	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update** **Committee Recommendation**			Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh		Laparoscopy, surgical, rep of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	
4	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	**Office**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**144**	**n/a**	**144**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**60**	**n/a**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**12**	**n/a**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**72**	**n/a**	**72**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA		**5**		**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA		**20**		**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**		**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**20**		**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**7**		**7**
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
39	Discharge day mgmt 99238 –12 min, 99239 –15 min	**L037D**	RN/LPN/MTA		**12**		**12**
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36		**2**		**2**
50	99214 53 minutes		53				
51	99215 63 minutes		63				
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**0**	**72**	**0**	**72**
54	**End: with last office visit before end of global period**						
55	**MEDICAL SUPPLIES**	**Code**	**Unit**				
56	pack, minimum multi-specialty visit	**SA048**	**pack**		**2**		**2**
57	pack, post-op incision care (suture)	**SA054**	**pack**		**1**		**1**
58							
59	**Equipment**	**Code**					
60	table, power	**EF031**			**72**		**72**
61	light, exam	**EQ168**			**72**		**72**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Endoscopic Pancreatoscopy

The CPT Executive Committee considered a request from the American College of Gastroenterology, the American Gastroenterological Association and the American Society of Gastrointestinal Endoscopy to revise the parenthetical following code 43273 to include code 43262 to the list of codes appropriately reported in addition to code 43273 *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure).*

The CPT Executive Committee questioned how the RUC considered sphincterotomy services and the frequency that sphincterotomy would be required for scope placement and therefore voted to reject the appeal and uphold the current position of the Panel pending determination by the RUC that sphincterotomy is not included in 43273. The RUC reviewed the background of the issue beginning with the addition of the code to CPT in February 2008 and discovered that the modifications to the parentheticals were changed by the CPT Editorial Panel after the survey initiation date. Therefore, the specialties developing recommendations for this code used the original parenthetical which included 43262 in their survey instrument. The RUC reviewed this service at its April 2008 meeting with 43262 included in the parenthetical and as a code listed in the summary of recommendation form as being a primary code for the add-on code. **Given this information, the RUC recommends that 43262 be added to the parenthetical following the descriptor for 43273 and that the intra-service description of work be modified as described below:**

> **After informed consent is obtained, the patient is brought to the therapeutic endoscopy suite. Sedation is administered intravenously, and the duodenoscope is introduced through the mouth with inspection of the esophagus, stomach and duodenum. Selective cannulation of the bile duct is obtained followed by multiple views of the cholangiogram under fluoroscopy. A guidewire is passed such that the tip is in the proximal biliary tree, and a standard biliary sphincterotomy is performed, which is reported separately.**
>
> **The cholangioscope is passed through the duodenoscope and into the biliary tree. Direct visualization is performed with careful inspection of the biliary and pancreatic epithelium. The mass lesion is identified and multiple biopsies are taken. The right and left intrahepatic biliary tree, common hepatic duct and common bile duct are all viewed. The cholangioscope is then withdrawn and then passed into the pancreatic duct. At**

the conclusion of the procedure, the cholangioscope is withdrawn and the physician proceeds with the remainder of the ERCP procedure.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
+43273	AA1	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) (List separately in addition to code(s) for primary procedure) (Use 43273 in conjunction with 43260, 43261, 43262, 43263-43265, 43267-43272)	ZZZ	2.24 (No Change)

March 31, 2009

William Rich, III, M.D. FACS
Chairman
AMA / Specialty Society RVS Update Committee (RUC)
515 N. State St.
Chicago IL 60654

RE: CPT Executive Committee query regarding parenthetical for CPT code 43273

Dear Dr. Rich:

On behalf of the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) we are pleased to provide the following comments in response to a request from the CPT Editorial Panel regarding:

- code + 43273, *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s)*
  (List separately in addition to code(s) for primary procedure)
  (Use 43273 in conjunction with 43260, 43261, 43263-43265, 43267-43272)

At the February 2009 meeting, the CPT Editorial Panel and the CPT Executive Committee requested further information from our societies regarding the frequency that sphincterotomy would be required for scope placement in response to our request that the Panel revise the parenthetical following code 43273 to include code 43262 (*Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy / papillotomy*) to the list of codes appropriately reported in addition to code 43273. We appreciate the opportunity to provide additional guidance as the Panel and the RUC consider this request.

Code 43273, which describes an add-on service to ERCP procedures, was valued at the April 2008 RUC meeting, based on recommendations from our societies which utilized survey data obtained in the usual manner. The CPT Executive Committee's question is whether, in valuing 43273, the RUC included the work of sphincterotomy (code 43262) as part of the physician work. This question, in turn, hinges on whether the survey respondents included sphincterotomy work as part of their responses. We believe there is compelling evidence to indicate that they did not, and that the survey responses reflect the work of cholangioscopy / pancreatoscopy alone, without sphincterotomy.

Table 1 at the end of this letter provides the complete text which was presented to survey respondents who completed the questionnaires used to generate the data presented in April 2008. It will be observed that the word "sphincterotomy" does not appear anywhere in this text; moreover, no part of the work description suggests that such work is to be included in the procedure being surveyed. In addition, it will be noted that the CPT Code Descriptor specifically instructs respondents that 432XX is to be used in conjunction with the sphincterotomy code, 43262. It would certainly be difficult to imagine that the

respondents would have included the sphincterotomy work element in their valuation of the code given these instructions and this clinical vignette.

Second, there are good data to indicate that more often than not a sphincterotomy has already been performed in such patients in an earlier ERCP procedure prior to the cholangioscopy/pancreatoscopy. Table 2 shows data recently presented in a peer reviewed forum (Chen et al., 2008) regarding patients who have undergone cholangioscopy. In this series of 297 subjects, 77% (229/297) had already undergone sphincterotomy during an ERCP procedure prior to the cholangioscopy. Of note, of those patients who did undergo a sphincterotomy during the procedure in which the cholangioscopy was performed, the sphincterotomy was unrelated to the cholangioscopy procedure in 59% (39/66) of patients. This is in keeping with the clinical scenario we have reported to the CPT Executive Committee.

In addition, the comment that a sphincterotomy is often performed during the ERCP procedure and is therefore unrelated to the cholangioscopy is supported by Medicare claims data. Table 3 shows a subgroup analysis from 37,789 ERCP procedures in 2007 for three specific codes which are associated with diseases for which cholangioscopy or pancreatoscopy are indicated. These data show that ERCP patients require sphincterotomy in over 50% of the time that ERCP procedures are reported. These findings are directional in that they suggest that sphincterotomy will not always be directly related to cholangioscopy. Hence, data exist from two independent sources supporting the conclusion that a sphincterotomy is NOT uniformly performed as part of cholangioscopy and that in the majority of cases, sphincterotomy, when provided, is unrelated to the cholangioscopy / pancreatoscopy. The survey respondents, being experienced with this fact, would not be expected to include the work of sphincterotomy in their responses.

In summary, we feel confident that the data presented to the RUC in April 2008 which formed the basis for the valuation of code 43273 did not include the work of sphincterotomy, code 43262, and that the RUC did not, either intentionally or accidentally, include this work in their valuation. We therefore recommend that the RUC advise the CPT Executive Committee that sphincterotomy is not included in the work of cholangioscopy/pancreatoscopy, code 43273 and we do not recommend an RVU change; the parenthetical which proscribes the concurrent use of code 43262 with 43273 should be amended to allow the concurrent use of the two codes, and the phrase "(separately reported)" should be inserted into the intra-service work description.

Thank you for the opportunity to submit this recommendation.

Sincerely,

Joel V. Brill, MD AGAF
AGA representative to
the CPT/RUC Advisory
Committee

Nicholas Nickl, MD
ASGE representative to
the RUC Advisory
Committee

Table 1: Text of 43273 survey instrument

Survey element	Survey text
CPT Code Descriptor (emphasis added)	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure) **(Use 432XX in conjunction with** 43260, 43261, **43262**, 43264, 43265, 43267, 43268, 43269, 43271, and 43272)
Typical Patient/Service	A 60-year old male presents with severe epigastric pain with radiation to the back. An abdominal ultrasound shows a normal gallbladder without stones and normal gallbladder wall thickness. An abdominal CT scan reveals a markedly dilated pancreatic duct at 1cm in diameter and a normal biliary tree. An ERCP reveals an enlarged ampulla of Vater with a markedly dilated opening and mucin in the orifice. Pancreatoscopy is performed to evaluate a presumed intraductal papillary mucinous neoplasm.

Source: AMA Specialty Society RVS Update Committee Survey

Table 2: Case series of patients undergoing cholangioscopy

Patient group	Number (%)
Patients undergoing cholangioscopy with pre-existing sphincterotomy from a prior ERCP session	229 (77%)
Patients having no sphincterotomy prior to or during index cholangioscopy procedure	2 (1%)
Patients having sphincterotomy during index cholangioscopy procedure, but unrelated to the cholangioscopy	39 (13%)
Patients having sphincterotomy during index procedure, related to cholangioscopy	27 (9%)
Total	**297 (100%)**

Source: Chen YK, et al. Peroral Cholangioscopy (PO) Using a Disposable Steerable Single Operator Catheter for Biliary Stone Therapy and Assessment of Indeterminate Strictures – a Multi-center Experience Using Spyglass, DDW 2008

Table 3: Medicare claims data, selected CPT codes related to cholangioscopy / pancreatoscopy

Claims group	Number (%)
Code 43264, ERCP with stone extraction *(diseases: choledocholithiasis, pancreatic lithiasis)*	
43264 submitted alone	985 (9%)
43264 submitted with other codes, one of which was 43262 (ERCP with sphincterotomy)	6,125 (58%)
43264 submitted with other codes, none of which was 43262	3,490 (33%)
Code 43265, ERCP with lithotripsy *(diseases: choledocholithiasis, pancreatic lithiasis)*	
43265 submitted alone	60 (5%)
43265 submitted with other codes, one of which was 43262	609 (55%)
43265 submitted with other codes, none of which was 43262	436 (39%)
Code 43268, ERCP with stent placement *(diseases: biliary stricture, pancreatic stricture, biliary neoplasm, pancreatic neoplasm)*	
43268 submitted alone	2,428 (26%)
43268 submitted with other codes, one of which was 43262	5,200 (55%)
43268 submitted with other codes, none of which was 43262	1,882 (20%)

Source: 2007 Medicare PSF Data

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2008

Cholangioscopy-Pancreatoscopy

The clinical efficacy of cholangioscopy/pancreatoscopy is well established in the diagnosis and treatment of pancreaticobiliary disease. The CPT Editorial Panel met in February 2008 and agreed that the current endoscopic retrograde cholangiopancreatography (ERCP) codes do not adequately describe a cholangioscopy / pancreatoscopy procedure, which is a distinct and substantially different procedure from ERCP. The cholangioscopy / pancreatoscopy procedure is additive to a variety of ERCP procedures and ERCP codes are inadequate to describe this procedure. The Editorial Panel created CPT code 43273 *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)* to accurately report and describe the work associated with this complex procedure. It is estimated that 5-10% of all ERCPs will require this new service 43273.

223

The RUC reviewed the survey results from 55 practicing gastroenterologists for newly created add-code 43273. The survey respondents reported physician time in the pre and post period. As physician work is typically not performed in the pre and post period for an add-on code, the specialty concluded this was the result of the survey respondents' lack of familiarity with the concept of pre/intra/post time and the survey instrument for an add-on code. The societies concluded it would be appropriate to remove the pre- and post- time and back-out the associated work relative values from the survey median (3.25) to calculate their recommended work value of 2.24. The RUC calculated the work relative value for 43273 by taking the survey median 3.25 – ((25 minutes pre-service time x .0224) + (20 minutes post-service time x .0224)) = 2.24. The value of 2.24 work RVUs lies between the survey median (3.25) and the 25th percentile (2.00).

The RUC compared 43273 to the specialty survey's key reference service code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 2.39) and agreed that new service 43273 was similar; however, it is much more intense and requires more skill than code 43235. The RUC also questioned the intra-service time for this new service and was assured by the specialty society and other RUC members that the median survey intra-service time of 45 minutes was reasonable for the service provided. It was also explained that this new service can only be performed with an ERCP and not separately.

The RUC also compared the code 48400 *Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)* (work RVU = 1.95) and agreed that although both codes involve 45 minutes of intra-service time, a higher work value was justified because endoscopy is a more intense procedure requiring greater technical skill compared to an injection. The RUC agreed that the most accurate work value for new code 43273 is between the specialty's survey 25th percentile (2.00) and its median (3.25). The RUC also believed the specialty calculated value of 2.24 was reasonable and provided for the proper rank order amongst these reviewed services. **The RUC recommends a relative work value of 2.24 for CPT code 43273.**

Practice Expense:
The RUC recommends no direct practice expense inputs for this add-on code.

New Technology:
The RUC recommends that 43273 be added to the new technology list as this procedure utilizes new techniques.

Conscious Sedation
The RUC determined that conscious sedation was only inherent in code 43273.

224

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
⊘●+43273	W1	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure) (Use 43273 in conjunction with 43260, 43261, 43263-43265, 43267-43272)	ZZZ	2.24

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43273 Tracking Number W1 Specialty Society Recommended RVU: **2.24**

Global Period: ZZZ RUC Recommended RVU: **2.24**

CPT Descriptor: Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)
(Use 432XX in conjunction with 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year old male presents with severe epigastric pain with radiation to the back. An abdominal ultrasound shows a normal gallbladder without stones and normal gallbladder wall thickness. An abdominal CT scan reveals a markedly dilated pancreatic duct at 1cm in diameter and a normal biliary tree. An ERCP reveals an enlarged ampulla of Vater with a markedly dilated opening and mucin in the orifice. Pancreatoscopy is performed to evaluate a presumed intraductal papillary mucinous neoplasm.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 61%

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

Is moderate sedation inherent in your reference code (Office setting)? Yes

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

Description of Pre-Service Work:

Description of Intra-Service Work: After informed consent is obtained, the patient is brought to the therapeutic endoscopy suite. Sedation is administered intravenously, and the duodenoscope is introduced through the mouth with inspection of the esophagus, stomach and duodenum. Selective cannulation of the bile duct is obtained followed by multiple views of the cholangiogram under fluoroscopy. A guidewire is passed such that the tip is in the proximal biliary tree, and a standard biliary sphincterotomy is performed.

The cholangioscope is passed through the duodenoscope and into the biliary tree. Direct visualization is performed with careful inspection of the biliary and pancreatic epithelium. The mass lesion is identified and multiple biopsies are taken. The right and left intrahepatic biliary tree, common hepatic duct and common bile duct are all viewed. The cholangioscope is then withdrawn and then passed into the pancreatic duct. At the conclusion of the procedure, the cholangioscope is withdrawn and the physician proceeds with the remainder of the ERCP procedure.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2008
Presenter(s):	Joel V. Brill, MD (AGA) and Klaus Mergener, MD, PhD (ASGE)
Specialty(s):	American Gastroenterological Association (AGA) & American Society for Gatsrointestinal Endoscopy (ASGE)
CPT Code:	43273

Sample Size:	195	**Resp N:**	55	**Response:** 28.2 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	6.00	**10.00**	25.00	120.00
Survey RVW:	0.60	2.00	**3.25**	5.08	20.00
Pre-Service Evaluation Time:			**25.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	2.00	30.00	**45.00**	60.00	155.00

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

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	43273	**Recommended Physician Work RVU: 2.24**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.0**	**0.0**
Pre-Service Positioning Time:		**0.00**	**0.0**	**0.0**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.0**	**0.0**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	0.00	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	0.0	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**

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
43235	000	2.39	**RUC Time**

CPT Descriptor Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13133	ZZZ	2.19	**RUC Time**	9,840

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	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	117,239

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

Other Reference CPT Code	Global	Work RVU	Time Source
48400	ZZZ	1.95	**RUC Time**

CPT Descriptor Injection procedure for intraoperative pancreatography (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: 27 **% of respondents:** 49.0 %

TIME ESTIMATES (Median)	CPT Code: 43273	Key Reference CPT Code: 43235	Source of Time RUC Time
Median Pre-Service Time	0.00	28.00	
Median Intra-Service Time	45.00	20.00	
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	**45.00**	**63.00**
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	3.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.59	2.96
Urgency of medical decision making	4.37	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	2.93
Physical effort required	4.59	2.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.48	2.33
Outcome depends on the skill and judgment of physician	4.70	2.89
Estimated risk of malpractice suit with poor outcome	4.41	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.11	3.07
Intra-Service intensity/complexity	4.85	3.22
Post-Service intensity/complexity	4.07	3.04

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 American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of code +43273, Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s). This code was approved during the February 2008 CPT Editorial Panel meeting. *After reviewing the survey data, the societies recommend a work relative value unit (WRVU) 2.24 WRVUs and 45 minutes physician time (intra-service). The recommended value of 2.24 WRVU* is between the surve WRVU median (3.25) and 25th percentile (2.00).

Survey Process

The survey was disseminated to 195 practicing gastroenterologists. A total of 55 responses (28% response rate) were received.

2.24 WRVU Recommendation Development

The societies convened an expert panel to review the survey data for code +43273.

+43273 SURVEY DATA

RVU	
Low	0.60
25th	2.00
Median	**3.25**
75th	5.08
High	20.00

PHY TIME	
Pre-Service Time	
Median	25
Intra Time	
Low	2
25th	30
Median	**45**
75th	60
High	155
Post Time	
Median	20

The survey respondents reported physician time in the pre and post period. As physician work is typically not performed in the pre and post period for an add-on (ZZZ) code, the societies concluded this was the result of the survey respondents' lack of familiarity with the concept of pre/intra/post time and the survey instrument for an add-on code. The societies concluded it would be appropriate to remove the pre- and post- time and back-out the associated WRVUs from the survey median:

Survey Median = 3.25 WRVU

3.25 - ((25 x .0224) + (20 x .0224)) = **2.24 WRVU**

Using the Median intra-service time of 45 minutes, a WRVU of 2.24 results in an IWPUT of 0.050 (2.24/45). The value of 2.24 WRVU falls in between the survey median and 25th percentile. The expert panel concluded that this was an appropriate value for the service.

Data Evaluation

As a next step of analysis the advisors compared the recommended WRVU and time values of code +43273 with the reference code and other similar services.

Physician Time and WRVU Data for Reference and Other Related Services						
CPT Code	**Pre Time**	**Intra Time**	**Post Time**	**Total Time**	**WRVU**	**IWPUT**
43235* - Upper GI Endoscopy, Diagnosis	28	20	15	63	2.39	0.075
48400 – Injection, Intraop, Add-On		45		45	1.95	0.043
99358 – Prolonged E/M services, first hour		60		60	2.10	0.035

* Survey reference service

+43273 versus 43235

The expert panel compared +43273 to the reference service code 43235. 49% of the survey respondents chose this code as the reference service. The society is recommending a lower WRVU for +43273 (2.24) than the WRVU value of the reference service 43235 (2.39).

The advisors concluded that the relative relationship between these two codes was appropriate.

- The intra-service time of +43273 is more than twice as long as the intra-service period for 43235 (45 minutes versus 20 minutes). The value of the intra-service work portion of code 43235 is approximately 1.50 WRVU for 20 minutes of intra time.
    - 2.39 - ((18*.0224) + (5*.008) + (5*.0224) +(15*.0224)) = 1.4988 = 1.50
- The recommended value for +43273 (2.24) is less than 50 percent higher when compared to the intra-service WRVU for code 43235. Code +43273 is a procedure of much greater complexity, involving intra time over twice as long.
    - Although the recommended RVU for +43273 results in a slightly lower IWPUT than for 43235, the respondents indicated the surveyed procedure was of greater intensity and required much more skill than code 43235. The expert panel agreed that +43273 was a more intense service than 43235, which supported the WRVU recommendation of 2.24.

+43273 versus 48400

The expert panel compared +43273 to 48400 which has a WRVU value of 1.95. The panel concluded that the relative relationship between these two codes was appropriate.

- While the two codes have the same intra-service time of 45 minutes, the expert panel concluded that the higher WRVU for code +43273 was justified because endoscopy was a more intense procedure requiring greater technical skill compared to injection.

+43273 versus 99358

The expert panel compared +43273 to 99358 which has a WRVU value of 2.10. The panel concluded that the relative relationship between these two codes was appropriate.

- Code 99358 has more intra-service time (60 minutes) but a lower WRVU (2.10) in comparison to +43273.
- Advisors concluded that this was justified because code 99358 reflected prolonged evaluation and management services, while code +43273 reflected a more intense procedural service requiring greater technical skill.

In view of the above, the AGA and ASGE recommend 2.24 WRVUs and physician time of 45 minutes (intra-service) for code +43273.

SERVICES REPORTED WITH MULTIPLE 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. The following CPT codes are identified as the primary or base code for the add-on code +432XX: 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272

Primary Codes for Add-On Code +432XX

Code	Global	WRVU	Time Source	Pre-Time	Intra-Time	Post-Time
43260	0	5.95	RUC	20	46	20
43261	0	6.26	RUC	20	55	20
43262	0	7.38	HARVARD	50	75	28
43263	0	7.28	RUC	47.5	76	40
43264	0	8.89	HARVARD	50	69	28
43265	0	10.00	RUC	40	83.5	35
43267	0	7.38	HARVARD	47	62	25
43268	0	7.38	HARVARD	51	78	29
43269	0	8.20	RUC	40	71	30
43271	0	7.38	HARVARD	47	61	26
43272	0	7.38	RUC	25	60	20

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Unique codes that describe cholangioscopy / pancreatoscopy currently do not exist. As such, current coding is very inconsistent. A variety of codes + modifiers are used when reporting a cholangioscopy / pancreatoscopy procedure including:

- 47999, Unlisted procedure, Biliary tract
- 48999, Unlisted procedure, pancreas
- 43260 + 47999, ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing + Unlisted procedure, Biliary tract
- 43260+48999, ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing + Unlisted procedure, pancreas
- 43260 - 22, ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing with Service Modifier
- 47550, Add-on code: Biliary Endoscopy, intraoperative (choledochoscopy)

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

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 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 Gastroenterology Frequency 2000 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? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The number is based on input from the manufacturer who has conducted an analysis of Medicare and private payor claims data.

Specialty Gastroenterology Frequency 800 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. 43260.
The expert panel concluded that one of the primary codes (ERCP codes: 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272) associated with the add-on code +432XX would make the most appropriate PLI crosswalk. The base ERCP code 43260 was selected by the expert panel.

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

William Thorwarth, MD
Chair, CPT Editorial Panel
American Medical Association
515 N. State St.
Chicago IL 60654

November 21, 2008

Dear Dr. Thorwarth,

On behalf of the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), we are writing to respond to the AMA CPT Editorial Panel's Executive Committee's request for clarification on whether the description of code 43273 Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure) overlaps with the procedure reported with code 43262, Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy.

Code 43273 cholangioscopy / pancreatoscopy, describes the direct visualization of the biliary and/or pancreatic ducts. Direct visualization of the pancreatic and/or biliary tree allows for inspection and treatment of abnormalities that may not be detected radiographically. When performed, the cholangioscopy / pancreatoscopy service is separate and distinct from an ERCP procedure, whether the ERCP does or does not involve sphincterotomy. When performed for medically necessary reasons, it would be appropriate for physicians to be able to report 43273 together with 43262.

It is important to note that although there may have been some question among Editorial Panel members of whether ERCP with sphincterotomy was included in the description of CPT code 43273, the description of the procedure that was provided to physicians as part of the valuation survey (shown below) did not include sphincterotomy:

"Typical Patient/Service: A 60-year old male presents with severe epigastric pain with radiation to the back. An abdominal ultrasound shows a normal gallbladder without stones and normal gallbladder wall thickness. An abdominal CT scan reveals a markedly dilated pancreatic duct at 1cm in diameter and a normal biliary tree. An ERCP reveals an enlarged ampulla of Vater with a markedly dilated opening and mucin in the orifice.

Pancreatoscopy is performed to evaluate a presumed intraductal papillary mucinous neoplasm."

On reviewing the physician surveys submitted to the RBRVS Update Committee (RUC) when this procedure was valued earlier this year, ERCP with sphincterotomy was not part of the valuation of CPT Code 43273. Specifically, sphincterotomy was not included in the service description of the cholangioscopy / pancreatoscopy service that was surveyed. The code descriptor that was sent to those surveyed did show 432XX as an add-on procedure and clearly states to report in conjunction with the applicable ERCP codes (i.e. the parenthetical instruction was part of what those surveyed saw). The RUC identified that the valuation of 43273 should be lower than the valuation of an ERCP procedure.

On behalf of the ACG, AGA and ASGE, we recommend that the AMA amend the parenthetical associated with CPT Code 43273 to read (change highlighted in bold italic font): (Use 43273 in conjunction with 43260, 43261, **43262**, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272). This change should be made as soon as possible and be made retroactive and retrospective to January 1, 2009 so that providers can be reimbursed appropriately.

We appreciate the Panel's consideration of our clarification and request and look forward to your decision. Should you have any questions on our comments please contact Brad Stillman, American College of Gastroenterology at bstillman@acg.gi.org or (301) 263-9000, Shovana Sloan, American Gastroenterological Association at ssloan@gastro.org or (301) 272-1601, or Sheila Madhani, Consultant to the American Society for Gastrointestinal Endoscopy at sheila@marcassoc.com or (202) 833-0007.

Sincerely,

Daniel DeMarco, MD	Joel V. Brill, MD	Glenn Littenberg, MD
ACG	AGA	ASGE

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Laparoscopic Longitudinal Gastrectomy

In October 2008, the CPT Editorial Panel created a new code to describe a complex anatomic and metabolic weight loss operation that has been increasingly used as a primary operation for morbid obesity.

The RUC reviewed code 43775 *Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)* and compared it to code *43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only* (work RVU = 20.64, intra-service time = 120 minutes). The RUC reviewed the pre-service time and agreed with the specialty society that pre-service time package 4 FAC Difficult patient/difficult procedure with some modifications was appropriate. The RUC agreed that an additional 22 minutes of positioning time was appropriate (25 minutes total positioning time) to account for additional positioning and padding the morbidly obese patient in reverse Trendelenburg, including positioning the laparoscopic equipment/monitors so the surgeon and assistants may visualize and perform the operation. The RUC determined that the intra-service time of 120 minutes and immediate post-service time of 30 minutes appropriately accounts for the physician time required to perform this service and was identical to code 43771.

The specialty society indicated and the RUC agreed that the survey respondents over-estimated the physician work required to perform this service, as the survey median RVU would place this service out of rank order with this family of services. Therefore, the following building block was used to develop a relative value unit. Starting with code *43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only* (work RVU = 20.64, intra-service time = 120 minutes), another gastric restrictive procedure with identical intra-service time but one less hospital visit, and adding one 99321 hospital visit to arrive at a work RVU of 21.40 for 43775 (20.64 + 0.76 = 21.40), which is less than the survey 25th percentile work RVU. Additionally, the specialty society indicated and the RUC agreed that one 99214 visit is necessary because the typical patient is nauseated and requires lengthy dietary and fluid balance education on the first post-operative visit. **The RUC recommends a work RVU of 21.40 for code 43775.**

The RUC also agreed with the specialty society's additional rationale comparing 43775 to survey respondents key reference service 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU = 29.24, intra-service time of 180 minutes) which has similar intensity and complexity measures. However, the

survey data indicated 43775 will require 60 minutes less intra-service time and one less hospital day (99232) than 43644. By subtracting the 60 minutes less IWPUT and one less 99232 from 43644 the resulting work RVU is 21.37 (which is almost identical to the primary building block resulting RVU of 21.40).

Additional rationale:
29.24 RVU for 43644
-6.48 60 min less x 0.108 (IWPUT for 43644)
-1.39 1 less 99232
21.37

The RUC also compared 43775 to code 43330 *Esophagomyotomy (Heller type); abdominal approach* (work RVU = 22.06, 120 minutes intra-service time) which requires similar physician time and work. **The RUC recommends a work RVU of 21.40 for code 43775.**

237

New Technology
The RUC recommends that code 43775 be placed on the new technology list.

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs for code 43775.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•43775	BB1	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy) (For open gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty, use 43483)	090	21.40
43843		Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty (For laparoscopic longitudinal gastrectomy (ie, sleeve gastrectomy), use 437XX)	090	21.08 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43775 Tracking Number BB1 Specialty Society Recommended RVU: **21.40**

Global Period: 090 RUC Recommended RVU: **21.40**

CPT Descriptor: Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old woman presents with a life-long history of obesity and diet history that confirms morbid obesity (BMI greater than 40). She has been refractory to medical weight loss management and elects to undergo laparoscopic longitudinal gastrectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 15% , Admitted (more than 24 hours) 85%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 71%

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

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

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

Description of Pre-Service Work: Assure appropriate selection, timing, and administration of DVT prophylaxis. Determine indication for intra-operative antibiotics and prescribe as necessary. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, and update H&P. Record patient weight. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment. Assist in transfer of patient from gurney to operating table. Assist anesthesia team with line placement and induction of anesthesia and intubation. Monitor/assist with positioning of patient. 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 general anesthesia, surgical laparoscopy is performed. Pneumoperitoneum is tablished to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are refully monitored so as not to impair ventilation or venous return. Four to six trocar ports are sited through the anterior abdominal wall above the umbilicus. The viscera are inspected. An orogastric tube may be placed to decompress the stomach. The liver is retracted to allow visualization of the stomach to the esophageal hiatus. The Angle of His is exposed by dissecting the peritoneal attachments. From a site approximately 4-6 cm proximal to the pylorus, the gastrocolic ligament is opened and divided cephalad along the greater curvature. The dissection and

division is carried through the gastro-splenic ligament and the short gastric vessels until the angle of His is reached. The posterior attachments of the stomach to the lesser sac are then dissected to free the lesser curvature. A Bougie or wide bore tube is passed though the mouth into the stomach and with laparoscopic visualization, is positioned along the lesser curvature. Starting proximal to the pylorus and staying parallel to the bougie the greater curve of the stomach is th divided longitudinally with several firings of an endoscopic stapler until the Angle of His is reached. Care is taken exclude the entire fundus of the stomach and to not impinge on the GE junction. The staple line may be over sewn or otherwise sealed per surgeon preference. Staple line integrity is checked to exclude leaks. The resected stomach segment is placed in a retrieval bag and extracted with enlargement of one of the trocar site incisions. The extraction site is closed at the fascia. The operative field is carefully inspected to ensure good hemostasis. A drain may be placed per surgeon preference along the gastric staple line. The liver retraction is released, and the trocars are removed. The incisions are closed.

Description of Post-Service Work:
Hospital:
Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia. 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 including need for patient controlled analgesia. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart and record. Dictate operative report and copy referring physician(s). Discontinue perioperative antibiotic therapy as appropriate. Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. Order x-rays (e.g. barium esophagram) as per routine. 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. Monitor and document patient progress. 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, x-rays, medications, diet, and patient activity. Chart patient progress notes, daily. Review available x-rays (if ordered). Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriat Discuss in detail dietary restrictions for the immediate post-operative period (e.g. liquid or mechanical soft diet and it duration) and coordinate continuing care by nutritionist. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (i.e., diet as above, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when there is return of bowel function, adequate nutritional intake, and adequate pain control with oral analgesics. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office:
Talk with and examine patient. Remove dressings, sutures, when appropriate. Review activity and restrictions. Monitor healing of incisions with appropriate physical examination Assess effect of procedure with current weight. Answer patient/family questions. Write prescriptions for medication and therapy, as necessary. Coordinate continuing care by nutritionist. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Michael Edye, MD, FACS; Christopher Senkowski, MD, FACS				
Specialty(s):	general surgery, bariatric surgery, laparoscopic surgery				
CPT Code:	43775				
Sample Size:	300	**Resp N:**	95	**Response:**	31.6 %
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	30.00	150.00
Survey RVW:	20.00	26.00	**28.50**	29.24	40.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	50.00	90.00	**120.00**	120.00	200.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	43775	**Recommended Physician Work RVU: 21.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**25.00**	**3.00**	**22.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43644	090	29.24	**RUC Time**

CPT Descriptor Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 51 **% of respondents:** 53.6 %

TIME ESTIMATES (Median)	CPT Code: 43775	Key Reference CPT Code: 43644	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	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	79.0	79.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**412.00**	**502.00**	
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	4.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.53	4.46
Urgency of medical decision making	3.10	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	4.61	4.75
Physical effort required	4.29	4.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.69	4.65
Outcome depends on the skill and judgment of physician	4.78	4.69
Estimated risk of malpractice suit with poor outcome	4.84	4.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.34	4.30
Intra-Service intensity/complexity	4.40	4.47
Post-Service intensity/complexity	3.96	4.00

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.*

Comparison to key reference code: 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*

New code 4377X *Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)* was created to report a complex anatomic and metabolic weight loss operation that has been increasingly

used as a primary operation for morbid obesity. In comparison to the key reference code, the pre-service evaluation and positioning of morbidly obese patients would be essential identical for the new code. Although intra-operative intensity and complexity are similar for both 43644 and 43775, the new procedure is more rapidly performed. Post-operative hospital stay for 43644 may be one day longer, but follow-up office visit work is the same.

Pre-Time: With respect to the pre-service time, we recommend package 4 (difficult patient / difficult procedure) with modification to positioning:

- Evaluation: no change (40 min)
- Positioning: Add 22 minutes (total = 25 min) to account for additional positioning and padding the morbidly obese patient in reverse Trendelenburg, including positioning the laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. This total time of 25 minutes is consistent with other laparoscopic gastric restrictive procedures that the RUC has accepted as reasonable time for this component.
- Scrub/Dress/Wait: no change (20 min)

RVW Recommendation:
As support, we compare this recommendation to another gastric restrictive procedure with similar intra-time and office time, but one less hospital day - 43771 *Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only*: **The consensus committee reviewing the survey data recommends an RVW of 21.40**

20.64 RVW for 43771
+0.76 1 more 99231
21.40

The survey intensity and complexity measures for the reference code and survey code are almost identical. However, the survey data indicate the new code will require 60 minutes less intra-operative time and one less day in the hospital., to account for these differences, as presented below:

29.24 RVW for 43644
-6.48 60 min less x 0.108 (IWPUT for 43644)
-1.39 1 less 99232
21.37

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
43659 Unlisted laparoscopy procedure, stomach 43999 Unlisted procedure, stomach
43843-22 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty

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

Specialty general surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Bariatric surgery is performed at a rate of approximately 200,000 procedures per year in the United States. The majority of these are either gastric bypass or adjustable gastric banding. The rate of longitudinal gastrectomy is estimated at 1500 procedures per year.

Specialty general surgery Frequency 1500 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? 50
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 not typically performed on Medicare-aged patients.

Specialty general surgery Frequency 50 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. The reference code RVW and intra-time are significantly greater than 43775. We suggest code 43279 (Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed) which has a similar total time and RVW and involves a patient that has significant co-morbidities and intra-op risk.

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

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

CPT Long Descriptor:

BB1 43775 Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)

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 committee of general surgeons agree that this procedure would not be performed in an office setting and would not typically be an emergency procedure.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the facility to schedule space and equipment needed and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information including instructions on diet and changes to medications prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy with the PCP prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management and office visit related activities are performed.

	A	B	C	D	E
1				BB1	
2				43775	
3	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update** **Committee Recommendation**			Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	
4	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**188**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**116**
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**				
39	Discharge day mgmt 99238 --12 min, 99239 --15 min	**L037D**	RN/LPN/MTA		**12**
41	**End: Patient leaves office**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27		**1**
49	99213 36 minutes		36		**1**
50	99214 53 minutes		53		**1**
51	99215 63 minutes		63		
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**0**	**116**
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**	**Code**	**Unit**		
56	pack, minimum multi-specialty visit	**SA048**	**pack**		**3**
57	pack, post-op incision care (suture)	**SA054**	**pack**		**1**
58					
59	**Equipment**	**Code**			
60	table, power	**EF031**			**116**
61	light, exam	**EQ168**			**116**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Fistula Plug

CPT converted a Category III code to a Category I code to report anal fistula repair with a fibrin plug, as this form of treatment has become more widely used.

The RUC reviewed the survey data for 46707 *Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])* and agreed with the specialty society that an additional 7 minutes of positioning in the pre-service time period would be appropriate given that the patient needs to be placed in a prone jack-knife or dorsal lithotomy position and buttocks are effaced. The RUC compared the surveyed code to the key reference code 46280 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton* (Work RVU=6.28). The RUC noted that the surveyed code and its reference code have similar intra-service times, 40 minutes and 45 minutes, respectively. The RUC compared the intensity complexity measures of the surveyed code and reference code and noted that overall these services required equal amounts of technical skill, physical effort and mental effort to perform. However, the RUC did note that the intra-service time intensity is greater in the surveyed code as the surgeon must place a suture through the fistula track without disrupting the track integrity, attach the other end to the "plug" and then gently pull the plug through the fistula track with care until it is snug, whereas in the reference code a surgeon would place a fistula probe through the fistula track and cut the tissue above the probe and pass a seton through the fistula and tie the ends together. Based on these comparisons, the RUC agreed the specialty societies' recommended work RVUs for this procedure, 6.30 Work RVUs, the survey median. **The RUC recommends 6.30 Work RVUs for 46707.**

New Technology List:
As this service is currently being reported with a Category III code, the RUC recommended that this code be placed on the New Technology List.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies 090 day global standards.

250

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
46706		Repair of anal fistula with fibrin glue	010	2.41 (No Change)
•46707	CC1	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	090	6.30
Category III				
D 0170T		~~Repair of anorectal fistula with plug (eg, porcine small intestine submucosa (SIS)~~ (0170T has been deleted. To report, see 46707)		N/A

251

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:46707 Tracking Number CC1 Specialty Society Recommended RVU: **6.30**

Global Period: 090 RUC Recommended RVU: **6.30**

CPT Descriptor: Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 44-year-old male presents with a 3-month history of perianal itching, pain, and drainage. Four months ago he had a perianal abscess incised and drained. Physical exam reveals an external os (opening) in the posterior anal space with drainage of mucus with no signs of acute infection or recurrent abscess. Upon anoscopy there is an internal os (opening) directly in the mid line at the dentate line. The diagnosis of a transsphincteric fistula of the deep posterior anal space is confirmed. Repair of the anal fistula with a cellular xenogeneic plug is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 65% , In the ASC 23%, In the office 13%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 94% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

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

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

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

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Confirm pre-operative enemas have been carried out. Review pre-operative work-up and labs. Review prior diagnostic studies. Reexamine patient to make sure that physical findings have not changed and update H&P. Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient/family. Obtain informed consent. Change into scrub clothes. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Assist with patient positioning (typically prone jackknife or dorsal lithotomy). The perineum is prepped and draped in a sterile fashion and the buttocks are taped apart. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, A Hill - Ferguson rectal retractor is placed into the anus and isolation and identification of the internal os is made by passing a series of fistula probes through the fistula tact into the anus. The fistula tract is thoroughly cleaned, irrigated, and debrided. At this time the cellular xenogenic plug is placed in normal saline for 5 to 7 minutes. A large fistula probe is then passed through the external opening and advanced through the tract until it extends through the internal opening. A suture is passed through the tail of the soaked plug. The plug is then pulled into the fistula tract and drawn through the tract until the wider end is tightly aligned with the internal opening, with the "tail" extending distally through the external opening. The internal end of the plug is sutured into

place, being careful to also close the internal opening of the fistula tract. Excess "tail" protruding from the external opening is trimmed off and the distal end of the plug sutured to the skin at the external opening, being careful to leave this open for drainage. A long acting local anesthetic is injected into the perianal area for comfort postoperatively.

Description of Post-Service Work: Facility: Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Examine patient to assess for the development of complications (eg, plug migration, bleeding). Dictate operative report (copy PCP and/or referring physician) and complete medical record documentation. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions, especially diet, activity, bathing. Reconcile medications and write orders for post-discharge medication. Complete all appropriate medical records, including discharge summary and discharge instructions, and insurance forms.

Office: Examine and talk with patient. Discuss diet, activity and hygiene. A diagnostic anoscopy will be performed at one or more office visits to assess resolution of fistula. Write prescription orders, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Guy Orangio, MD, FACS				
Specialty(s):	colon and rectal surgery				
CPT Code:	46707				
Sample Size:	150	**Resp N:**	48	**Response:** 32.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	4.00	**6.00**	10.00	70.00
Survey RVW:	3.00	6.00	**6.30**	6.50	10.00
Pre-Service Evaluation Time:			**33.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	30.00	**40.00**	40.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	46707	**Recommended Physician Work RVU: 6.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
46280	090	6.28	**RUC Time**

CPT Descriptor Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 58.3 %

TIME ESTIMATES (Median)	CPT Code: 46707	Key Reference CPT Code: 46280	Source of Time RUC Time
Median Pre-Service Time	58.00	60.00	
Median Intra-Service Time	40.00	45.00	
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	19.00	
Median Office Visit Time	55.0	55.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**187.00**	**199.00**	
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	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.79
Urgency of medical decision making	2.36	2.35

Technical Skill/Physical Effort (Mean)

Technical skill required	3.11	3.11
Physical effort required	2.46	2.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.64	2.64
Outcome depends on the skill and judgment of physician	3.54	3.54
Estimated risk of malpractice suit with poor outcome	2.89	2.96

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.36	3.25
Intra-Service intensity/complexity	3.21	3.00
Post-Service intensity/complexity	2.79	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.*

Surgeons have a number of procedural options for treating anal fistulae. These include fistulotomy, fistulectomy, fibrin glue injection, seton placement, and endorectal advancement flap closure. A Category III code for fibrin plug became effective for reporting purposes January 1, 2007. Because this treatment has become more widespread, a change from Cat III code to Cat I was approved for CPT 2010.

Comparison to key reference code: 46280 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton*

New code 467X1 *Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])* has become mor widely used and the literature has shown the procedure has efficacy. In comparison to the key reference code, all components of time (pre, intra, post) for the new code would be the same. However, new code 46707 is more intense/complex than 46280. Intra-operatively, the surgeon must place a suture through the fistula track with out disrupting the track integrity, attach the other end to the "plug," and then gently pull the plug through the fistula track with care until it is snug. Then place a suture seromuscularly through the internal os then through the plug with out disrupting the plug or it's position, then approximate the mucosa of the rectum over the plug (internal os). Then place a similar suture through the external os, skin through plug then skin to close the aperture of the external os with the plug just under the skin. This is more intense / complex than 46280 where you place a fistula probe through the fistula track and cut the tissue above the probe and pass a seton through the fistula and tie the ends together.

Pre-Time: With respect to the pre-service time, we recommend package 3 (straightforward patient / difficult procedure):

- Evaluation: no change (33 min)
- Positioning: Add 7 minutes (total = 10 min). Patient is positioned prone jackknife or in dorsal lithotomy and buttocks are effaced.
- Scrub/Dress/Wait: no change (15 min)

RVW Recommendation: The survey intensity and complexity measures for the survey code are very similar or slightly greater than the reference code, including the intra-service complexity.. **The consensus committee reviewing the survey data recommend the survey median RVW of 6.30.**

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 unliste code is reviewed) 0170T Repair of anorectal fistula with plug (e.g. porcine small intestine submucosa (SIS)

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 colon and rectal surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000
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 sales data since the device's product launch in May, 2005, it is estimated that this procedure is performed approximately 5,000 times annually.

Specialty colon and rectal surgery Frequency 4000 Percentage 80.00 %

Specialty general surgery Frequency 1000 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? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Anal fistulae are not primarily a disease of the 65+ population, so Medicare utilization will be a small fraction of that number.

Specialty colon and rectal surgery Frequency 80 Percentage 80.00 %

Specialty general surgery Frequency 20 Percentage 20.00 %

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. Surgical

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

CPT Long Descriptor:

46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])

Sample Size: N/A 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:

A consensus committee of colon and rectal surgeons representing all types of practices and all geographic settings discussed the practice expense details for new code CC1. The consensus was that neither of this procedure would not be performed in the office setting. Additionally, the committee agreed that at least one of the follow-up office visits would require an anoscopy that would not be separately billable. Further the consensus was that the clinical staff work, supplies, and equipment necessary for key reference code 46280 are the same for new code CC1. These are shown on the Excel file and crosswalked to the new code.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the facililty to schedule space and equipment needed and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information including instructions on diet and bowel cleansing prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management and office visit related activities are performed.

	A	B	C	D	E
1				CC1	
2				46707	
3	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update** **Committee Recommendation**			Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	
4	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**156**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**90**
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**				
39	Discharge day mgmt 99238 –12 min, 99239 –15 min	**L037D**	RN/LPN/MTA		**6**
41	**End: Patient leaves office**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27		**2**
49	99213 36 minutes		36		**1**
50	99214 53 minutes		53		
51	99215 63 minutes		63		
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**0**	**90**
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**	**Code**	**Unit**		
56	pack, minimum multi-specialty visit	**SA048**	**pack**		**3**
57	lubricating jelly (K-Y) (5gm uou)	**SJ032**	**item**		**4**
58	swab, procto 16in	**SJ052**	**item**		**3**
59	pack, post-op incision care (suture)	**SA054**	**pack**		**1**
60	anoscope	**SD003**	**item**		**1**
61	pack, cleaning and disinfecting, endoscope	**SA042**	**pack**		**1**
62	**Equipment**	**Code**			
63	table, exam	**EF023**			**90**
64	light, exam	**EQ168**			**90**
65	anoscope with light source	**ES002**			**36**
66	light source, xenon	**EQ167**			**36**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Temporary Prostatic Urethral Stent Insertion

At its October 2008 meeting, the CPT Editorial Panel created 53855, *Insertion of a temporary prostatic urethral stent, including urethral measurement*, a Category I code to describe the work previously reported in Category III code, 0084T, *Insertion of a temporary prostatic urethral stent*, to accurately describe the measurement and insertion of a temporary prostatic stent as a stand alone procedure used as treatment for complications that follow microwave therapy (code 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*). Approximately 10% of patients who have microwave therapy may potentially require this procedure or placement of a foley catheter, which is the only present treatment.

The RUC reviewed the survey data from 30 urologists presented by the specialty society. The RUC reviewed the survey physician times and agreed that the median survey intra-service time of 15 minutes is appropriate. The RUC also agreed with the specialty society that pre-service time package 5, non-facility procedure without sedation or anesthesia, is appropriate. The RUC also agreed with the specialty society expert panel that the survey 25th percentile work RVU of 1.64 is appropriate. The RUC compared 53855 to key reference service 53620, *Dilation of urethral stricture by passage of filiform and follower, male; initial* (work RVU = 1.62), which reflects similarities to the time. The RUC concluded that the two services are similar and recommended the survey 25th percentile work RVU of 1.64. **The RUC recommends the survey 25th percentile work RVU of 1.64 for 53855.**

262

Modifier 51
The RUC recommends that 53855 not be placed on the modifier -51 exempt list because the procedure is performed within the global period of 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*, but never performed with 53850.

Practice Expense
The RUC reviewed the direct practice expense inputs for 53855 and approved the attached inputs.

New Technology
The RUC recommends that 53855 be placed on the New Technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲52282		Cystourethroscopy, with insertion of permanent urethral stent (For placement of temporary prostatic urethral stent, see code 53855)	000	6.39 (No Change)
●53855	H1	Insertion of a temporary prostatic urethral stent, including urethral measurement (For insertion of permanent urethral stent, see code 52282)	000	1.64
D 0084T		~~Insertion of a temporary prostatic urethral stent~~ (0084T has been deleted. To report, use 53855)		N/A

263

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:53855 Tracking Number H1 Specialty Society Recommended RVU: **1.64**

Global Period: 000 RUC Recommended RVU: **1.64**

CPT Descriptor: Insertion of a temporary prostatic urethral stent, including urethral measurement

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old man presents to his urologist for an evaluation of continuing lower urinary tract symptoms (LUTS) caused by prostatic enlargement. it is determined the patient is a candidate for a minimally invasive prostatic therapy. Two to five days following the minimally invasive therapy, the patient presents with temporary worsening symptoms (e.g. decreased voided volume, increase in post-void residual urine, urinary retention). A temporary prostatic urethral stent is placed to manage voiding dysfunction during the healing phase. (Prostatic thermotherapy, when performed, should be reported separately.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

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

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

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

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

Description of Pre-Service Work: The patient is draped and prepped for a typical sterile urethral device insertion procedure.

Description of Intra-Service Work: The length of the urethra from the bladder neck to the distal side of the external sphincter is measured using the measurement device. The appropriate length stent is selected to accommodate the patient's anatomical requirements and prepared for insertion. The stent and insertion tool is inserted into the urethra until the distal tip and balloon are positioned in the bladder. The balloon is then inflated; the urethral stent is positioned in the prostatic urethra and then deployed. The insertion tool is slowly withdrawn from the urethra. The stent's retrieval tether may be trimmed such that the distal end is just inside the urethra's meatus.

Description of Post-Service Work: The patient should be assessed to assure that the patient is able to void adequately prior to discharge from the clinic.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Richard Gilbert; MD; James Giblin, MD; Mitchell Humphreys, MD		
Specialty(s):	Urology		
CPT Code:	53855		
Sample Size:	124	**Resp N:** 30	**Response:** 24.1 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	9.50	50.00
Survey RVW:	1.32	1.64	**3.18**	5.39	6.39
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	5.00	12.00	**15.00**	30.00	45.00

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

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

Specialty Society Recommended Data

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

CPT Code:	53855	**Recommended Physician Work RVU: 1.64**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
53620	000	1.62	**RUC Time**

CPT Descriptor Dilation of urethral stricture by passage of filiform and follower, male; initial

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
62270	000	1.37	**RUC Time**	77,715

CPT Descriptor 1 Spinal puncture, lumbar, diagnostic

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57410	000	1.75	**RUC Time**	3,942

CPT Descriptor 2 Pelvic examination under anesthesia

Other Reference CPT Code	Global	Work RVU	Time Source
51703	000	1.47	**RUC Time**

CPT Descriptor Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 23.3 %

TIME ESTIMATES (Median)	CPT Code: 53855	Key Reference CPT Code: 53620	Source of Time RUC Time
Median Pre-Service Time	7.00	15.00	
Median Intra-Service Time	15.00	10.00	
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	**32.00**	**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	3.70	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	2.80
Urgency of medical decision making	3.60	3.40

Technical Skill/Physical Effort (Mean)

Technical skill required	3.60	3.40
Physical effort required	3.10	2.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.70	3.00
Outcome depends on the skill and judgment of physician	3.90	3.60
Estimated risk of malpractice suit with poor outcome	2.40	2.53

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.07
Intra-Service intensity/complexity	3.50	3.07
Post-Service intensity/complexity	2.60	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 AUA's RUC panel reviewed the survey responses and determined that the 25th percentile is an appropriate RV 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) 0084T

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? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Information provided by AbbeyMoor Medical, Inc., the manufacturer of the product used in this procedure.

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? 420
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Information provided by AbbeyMoor Medical, Inc., the manufacturer of the product used in this procedure. Note: Per the specialty, approximately 10% of those who receive microwave therapy may have complications that require 5385X.

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? 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
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility/Facility Direct Inputs

CPT Long Descriptor: Insertion of a temporary prostatic urethral stent, including urethral measurement

Sample Size: 124 Response Rate: (%): 24.1% Global Period: 000

Geographic Practice Setting %: Rural 2% Suburban 60% Urban 38%

Type of Practice %:
_____Solo Practice
100%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 recommendations were developed by a Panel consisting of six physicians who represents urological practices from across the United States in single specialty groups in suburban and urban settings. They represent the states of Washington, Illinois, Virginia, New York, South Carolina and Arizona. The panel reviews current information, makes recommendations and these recommendations are submitted to the AMA.

Please describe the clinical activities of your staff:
Pre-Service Clinical Labor Activities:
Review charts
Greet patient and provide gowning
Obtain vital signs
Provide pre-service education/obtain consent
Prepare room, equipment, supplies
Prepare and position patient/ monitor patient/ set up IV

Intra-Service Clinical Labor Activities:
Assist physician during procedure by monitoring patient
Handing instruments to the physician during procedure
Assist physician in measuring stent

	A	B	C	D	E
1				53855	
2	**AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Insertion of a temporary prostatic urethral stent, including urethral measurement**	
3	**LOCATION**	**Code**	**Type**	**Facility**	**Facility**
4	**GLOBAL PERIOD**			**0**	**0**
5	**TOTAL CLINICAL LABOR TIME**		**L037D**	**31.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**		**L037D**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		**L037D**	**28.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**		**L037D**	**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		**L037D**	**0**	**0**
12	Coordinate pre-surgery services		**L037D**	**0**	**0**
13	Schedule space and equipment in facility		**L037D**	**0**	**0**
14	Provide pre-service education/obtain consent		**L037D**	**0**	**0**
15	Follow-up phone calls & prescriptions		**L037D**	**0**	**0**
16	Other Clinical Activity (please specify)				
	End: When patient enters office/facility for surgery/procedure				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review charts		**L037D**		
21	Greet patient and provide gowning		**L037D**	**3**	
22	Obtain vital signs		**L037D**	**3**	
23	Provide pre-service education/obtain consent		**L037D**		
24	Prepare room, equipment, supplies		**L037D**	**2**	
25	Setup scope (non facility setting only)		**L037D**		
26	Prepare and position patient/ monitor patient/ set up IV		**L037D**	**2**	
27	Sedate/apply anesthesia		**L037D**		
28	**Intra-service**				
29	Assist physician in performing procedure (100%)		**L037D**	**15**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff		**L037D**	**3**	
33	Clean Scope				
34	Clean Surgical Instrument Package				
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
38	Discharge day management				

	A	B	C	D	E
1				53855	
2	**AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Insertion of a temporary prostatic urethral stent, including urethral measurement**	
3	**LOCATION**	**Code**	**Type**	**Facility**	**Facility**
39	Other Clinical Activity (please specify)				
40	**End: Patient leaves office**				
41	**POST-SERVICE Period**				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions		L037D	3	
44	*Office visits:*				
45	*List Number and Level of Office Visits*				
46	99211 16 minutes		16		
47	99212 27 minutes		27		
48	99213 36 minutes		36		
49	99214 53 minutes		53		
50	99215 63 minutes		63		
51	Other				
52	*Total Office Visit Time*			0	0
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
56	pack, minimum multi-specialty visit	SA048	1		
57	foley catheter	SD024	1		
58	drainage bag	SJ031	1		
59	leg bag	SD074	1		
60	drape, sterile barrier (16in x29in)	SB007	1		
61	drape, towel, sterile OR blue 2 pk	SB020	1		
62	drape, sterile for mayo stand	SB012	1		
63	**lidocaine 4% soln, topical (Xylocaine)**	**SH050**	**2**		
64	syringe 10-12 ml	SC051	1		
65	gloves, sterile	SB024	2		
66	sodium chloride 0.9% inj (250-1000ml uou)	SH067	1		
67	lubricating jelly (K-Y)(5gm uou)	SJ031	2		
68	**kit, prostatic urethral stent, insertion tool & surveyor (See invoice)**	**NEW**	**1**		
69	**Equipment**	**CMS Code**			
70	table, power	**EF031**	1	**28**	
71	light, exam	**EQ168**	1	**28**	
72	mayo stand	**EF015**	1	**28**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008

Laparoscopic Revision of Prosthetic Vaginal Graft

The CPT Editorial Panel created a new Category I code to describe the work associated with performing the excision, revision or removal of prosthetic vaginal material via the laparoscopic approach as this work is currently not captured accurately in CPT.

The RUC reviewed the specialty society survey data for 57426 *Revision (including removal) of prosthetic vaginal graft; laparoscopic approach*. The RUC discovered that the specialty society removed the post-operative visit times associated with 99232 Hospital Visit and a 99213 Office Visit from the survey data in their recommendation. The RUC agreed that the work RVUs associated with these visits should be removed from the survey median RVW, 16.46 RVUs. Removing this associated work results in a work RVU of 14.15. The RUC believed this value to be appropriate as it maintains rank order in comparison to several reference codes including: 57296 *Revision (including removal) of prosthetic vaginal graft; open abdominal approach* (RVU=16.46) which has a total service time of 429 minutes in comparison to the surveyed code which has a recommended total service time of 360 minutes and 51990 *Laparoscopy, surgical; urethral suspension for stress incontinence* (Work RVU=13.26) which has a total service time of 324 minutes in comparison to the surveyed code which has a recommended total service time of 360 minutes. **The RUC recommends 14.15 RVUs for 57426.**

276

The RUC also addressed the specialty society recommended frequency information. The specialty society recommended that this service will be performed nationally 200 times per year and 100 times a year to Medicare patients. The RUC noted that the coding proposal stated different statistics regarding this frequency data. The specialty society stated that this was an error on the coding proposal and that the frequency data supplied on the summary of recommendation form is correct.

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

New Technology:
Because this service represents new technology that has not been widely used, the RUC recommends that 57426 be added to the new technology list as well as 57425 *Laparoscopy, surgical, colpopexy (suspension of vaginal apex)*, as 57425 is a mirror service to 57426.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●57426	C1	Revision (including removal) of prosthetic vaginal graft; laparoscopic approach	090	14.15

277

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57426 Tracking Number C1 Specialty Society Recommended RVU: **16.23**

Global Period: 090 RUC Recommended RVU: **14.15**

CPT Descriptor: Revision (including removal) of prosthetic vaginal graft; laparoscopic approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 y/o G3 P3 female patient presents complaining of vaginal discharge, discomfort, and painful intercourse. She underwent abdominal sacral colpopexy using mesh about one year ago, which was uncomplicated. Her past medical history is negative. Her pertinent physical examination reveals mesh eroding through the apex of the vagina. Vaginal apical support is adequate. The surgeon decides that excision is necessary and performs this via the laparoscopic route.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 21%

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

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

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

Description of Pre-Service Work: 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: Access to the pelvis is achieved via laparoscopic approach. The vaginal tissue may be elevated by the surgeons free hand introduced vaginally or by an instrument placed within the vaginal cavity. The graft is identified and the peritoneum is opened over it.. Sharp dissection at the area of graft attachment to the vagina is performed. Care is taken not to dissect too deeply to avoid entering the bladder or rectum. The vaginal epithelium is dissected sharply around the eroding mesh, creating a plane between the vaginal epithelium and the endopelvic fascia. This dissection is taken circumferentially about 2 centimeters and the graft and attached tissue is removed. All of the eroding material is excised sharply being careful to avoid rectum, bladder, and small bowel. Once excision is complete, the remaining edges of the endopelvic fascia are re-approximated with delayed absorbable suture and the vaginal epithelium is also closed in layers. The portion of the graft that is attached to the pre-sacral ligament is then identified. Again, sharp dissection is completed being careful to avoid the significant vasculature here. The graft is removed as are the permanent sutures that were used to attach it. Skin wounds or vaginal mucosa are re-approximated. Irrigation is carried out and a urinary catheter is placed to complete the procedure.

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 2 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2008					
Presenter(s):	George Hill, MD					
Specialty(s):	American College of Obstetricians and Gynecologists					
CPT Code:	57426					
Sample Size:	295	**Resp N:**	19	**Response:** 6.4 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	10.00
Survey RVW:	7.84	16.23	**16.46**	17.50	19.50
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**110.00**	130.00	180.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **0.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**92.00**	99211x **0.00** 12x **0.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	57426	**Recommended Physician Work RVU: 16.23**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**110.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
57296	090	16.46	**RUC Time**

CPT Descriptor Revision (including removal) of prosthetic vaginal graft; open 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	Work RVU	Time Source	Most Recent Medicare Utilization
19318	090	15.91	**RUC Time**	6,393

CPT Descriptor 1 Reduction mammaplasty

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
65750	090	16.60	**RUC Time**	967

CPT Descriptor 2 Keratoplasty (corneal transplant); penetrating (in aphakia)

Other Reference CPT Code	Global	Work RVU	Time Source
51990	090	13.26	**RUC Time**

CPT Descriptor Laparoscopy, surgical; urethral suspension for stress incontinence

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 63.1 %

TIME ESTIMATES (Median)	CPT Code: 57426	Key Reference CPT Code: 57296	Source of Time RUC Time
Median Pre-Service Time	63.00	65.00	
Median Intra-Service Time	110.00	120.00	
Median Immediate Post-service Time	40.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	120.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**360.00**	**429.00**	
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	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.67
Urgency of medical decision making	3.33	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.67
Physical effort required	4.67	4.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.67	4.58
Outcome depends on the skill and judgment of physician	4.83	4.67
Estimated risk of malpractice suit with poor outcome	4.33	4.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.83	3.75
Intra-Service intensity/complexity	4.92	4.75
Post-Service intensity/complexity	3.42	3.42

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) 58999

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 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? 200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty ob/gyn 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.

Specialty ob/gyn 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

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:
57426; Revision (including removal) of prosthetic vaginal graft; 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 57426 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. 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 ducation/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 (3) level three office visits. The standard 36 minute time for the level three office visit was used. A total of 108 minutes has been applied for post-service clinical labor activities time.

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation				
2				57426	
3	Meeting Date: October 2008			Revision (including removal) of prosthetic vaginal graft; laparoscopic approach	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility
5	GLOBAL PERIOD		RN/LPN/MTA		90
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	NA	110.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA		12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D			108.0
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	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27		
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	108
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
58	kit, suture removal	SA031			1
59	pack, minimum multi-specialty visit	SA048			3
60	pack, pelvic exam	SA051			3
61	Equipment	CMS Code	Utilization Percentage		
62	power table	E11003	100%		108
63	fiberoptic exam light	E11006	100%		108
64					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

CT Colonography

The CPT Editorial Panel converted two Category III codes into three Category I codes to report diagnostic and screening computed tomographic (CT) colonography. This technology has now been in existence for over 10 years and there is enough widespread utilization of this technology to warrant the conversion of the Category III codes to Category I codes.

74261 ***Computed tomographic (CT), colonography, diagnostic, including image postprocessing; without contrast material***
The RUC reviewed the survey data for 74261 as compared to the reference code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=2.40) and noted that the intra-service times were very similar 40 minutes and 45 minutes, respectively. The RUC also removed 2 minutes of pre-service evaluation time as recommended by the specialty societies, as they agreed 5 minutes of evaluation time best reflected the service. Further, the RUC compared the surveyed code to another reference code, MPC code 78815 *Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh* (Work RVU=2.44) and noted very similar intra-service times, 40 minutes and 35 minutes respectively. In addition, the RUC compared the intensity/complexity measures of 74261 to its reference code 75635 and determined that the surveyed code required more technical skill and physical effort but less mental effort and judgment to perform than the reference code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 2.40 RVUs which is slightly below the survey's 25th percentile, as this value appropriately places the amount of work for this code in comparison to the other CT colonography codes and other codes in the RBRVS. **The RUC recommends 2.40 Work RVUs for 74261.**

74262 ***Computed tomographic (CT), colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed***
The RUC reviewed the survey data for 74262, a very uncommonly performed service as indicated by the low Medicare utilization estimate. The RUC compared the surveyed code to the reference code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=2.40) and noted that the intra-service times were the same, 45 minutes. Further, the RUC compared the surveyed code to another reference code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast*

material; (Work RVU=2.35) and noted very similar intra-service times, 45 minutes and 40 minutes respectively. Further, the RUC removed 2 minutes of pre-service evaluation time as recommended by the specialty societies, as they agreed 5 minutes of evaluation time best reflected the service. In addition, the RUC compared the intensity/complexity measures of 74262 to its reference code 75635 and determined that the surveyed code required more technical skill and physical effort, more psychological stress and was overall a more intense procedure to perform than the reference code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 2.50 RVUs, the 25th percentile of the survey data, as this value appropriately places the amount of work for this code in comparison to the other CT colonography codes and other codes in the RBRVS. **The RUC recommends 2.50 Work RVUs for 74262.**

74263 ***Computed tomographic (CT) colonography, screening, including image postprocessing***
The RUC reviewed the survey data for 74263 as compared to the reference code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=2.40) and noted that the surveyed code has less total service time than the reference code, 51 minutes and 70.50 minutes, respectively. Further, the RUC compared the surveyed code to another reference code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material;* (Work RVU=2.35) and noted that the surveyed code had less total service time than this reference code, 51 minutes and 60 minutes, respectively. Further, the RUC removed 1 minutes of pre-service evaluation time as recommended by the specialty societies, as they agreed 7 minutes of evaluation time best reflected the service. In addition, the RUC compared the intensity/complexity measures of 74263 to its reference code 75635 and determined that the surveyed code required less psychological stress, mental effort and judgment to perform as compared to its reference code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 2.28 RVUs, the 25th percentile of the survey data, as this value appropriately places the amount of work for this code in comparison to the other CT colonography codes and other codes in the RBRVS. **The RUC recommends 2.28 Work RVUs for 74263.**

New Technology List:
As these services are currently being reported with Category III codes, the RUC agreed with the specialty societies' recommendation that these codes should be placed on the New Technology List.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Colonoscopy is the examination of the entire colon, from the rectum... *Surgical endoscopy always includes diagnostic endoscopy.* For computed tomographic colonography, see 74261-74263.				
Radiology **Diagnostic Radiology (Diagnostic Imaging)** **Spine and Pelvis**				
72192		Computed tomography, pelvis; without contrast material	XXX	1.09 (No Change)
72193		with contrast material(s)	XXX	1.16 (No Change)
72194		without contrast material, followed by contrast material(s) and further sections (To report 3D rendering, see 76376, 76377) (For computed tomographyic, colonography, diagnostic see ~~Category III codes 0066T, 0067T~~74261-74262. For computed tomographyic, colonography, screening, use 74263) (Do not report 72192-72194 in conjunction with ~~0066T, 0067T~~74261-74263)	XXX	1.22 (No Change)
74150		Computed tomography, abdomen; without contrast material	XXX	1.19 (No Change)
74160		with contrast material(s)	XXX	1.27 (No Change)
74170		without contrast material, followed by contrast material(s) and further sections	XXX	1.40

290

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(To report 3D rendering, see 76376, 76377) (For computed tomographyic, colonography, diagnostic, see ~~Category III codes 0066T, 0067T~~74261-74262. For computed tomographyic, colonography, screening, use 74263) (Do not report 74150-74170 in conjunction with ~~0066T, 0067T~~74261-74263)		(No Change)
•74261	GG1	Computed tomographic (CT), colonography, diagnostic, including image postprocessing; without contrast material	XXX	2.40
•74262	GG2	with contrast material(s) including non-contrast images, if performed (Do not report 74261,74262, in conjunction with 74263, 72192-72194, 74150-74170, 76376-76377)	XXX	2.50
•74263	GG3	Computed tomographic (CT) colonography, screening, including image postprocessing (Do not report 74263 in conjunction with 74261-74262, 72192-72194, 74150-74170, 76376-76377)	XXX	2.28
76376		3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation (Use 76376 in conjunction with code(s) for base imaging procedure(s)) (Do not report 76376 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 74261-74263 75557-75564, 75635, 76377, 78000-78999, ~~0066T, 0067T~~, 0144T-0151T, 0159T)	XXX	0.20 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
76377		requiring image post-processing on an independent workstation (Use 76377 in conjunction with code(s) for base imaging procedure(s)) (Do not report 76377 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 74261-74263 , 75557-75564, 75635, 76376, 78000-78999, ~~0066T, 0067T~~0144T-0151T, 0159T)	XXX	0.79 (No Change)
D 0066T		~~Computed tomographic (CT) colonography (ie, virtual colonoscopy); screening~~		N/A
D 0067T		~~diagnostic~~ ~~(Do not report 0066T and 0067T in conjunction with 72192-7294, 74150-74170)~~ (0066T has been deleted. To report CT colon, screening use code 74263) (0067T has been deleted. To report CT colon, diagnostic see codes 74261-74262)		N/A

292

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 74261 Tracking Number GG1 Specialty Society Recommended RVU: **2.40**

Global Period: XXX RUC Recommended RVU: **2.40**

CPT Descriptor: Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with abdominal discomfort, iron deficiency anemia and guaiac positive stools. Optical colonoscopy was unsuccessful due to extreme redundancy of the colon.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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

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

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

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

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

Description of Pre-Service Work:

- Review the reason for the exam, any pertinent clinical history and any prior imaging studies.
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists.

Description of Intra-Service Work:

- Supervise insertion of rectal tube and instillation of room air or carbon dioxide.
- Review 2D [scout] topogram of abdomen and pelvis to ensure adequate colonic distention for each acquisition.
- Supervise acquisition of thin section, low-dose 2D CT images and review for adequacy.
- After ensuring continued adequate colonic distention, supervise acquisition of thin section, low-dose 2D CT images in the second position, typically prone, review for adequacy and instruct the technologist to acquire appropriate additional images if needed.
- Perform interactive manipulations of 3D image datasets (volume rendered, endoluminal and/or flythrough views) wi correlative multiplanar 2D reconstructions of datasets from all positions. Modify and perform additional targeted 3 reconstructions as necessary.
- Interpret both the supine and prone images of the colon (including decubitus if performed) using 2- and 3D reconstructions, including 3D endoluminal views, integrated with 2D multiplanar reformations and source images and compare to pertinent prior imaging studies.

- Dictate a report for the medical record.

Description of Post-Service Work:

- Review and sign report.
- Communicate significant results to referring physician and, when appropriate, discuss patient management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Paul Knechtges, MD				
Specialty(s):	ACR				
CPT Code:	74261				
Sample Size: 200	**Resp N:** 45	**Response:** 22.5 %			
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	12.00	**50.00**	150.00	1000.00
Survey RVW:	2.20	2.45	**2.50**	2.75	4.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**40.00**	45.00	60.00

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

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

Specialty Society Recommended Data

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

CPT Code:	74261	**Recommended Physician Work RVU: 2.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
75635	XXX	2.40	**RUC Time**

CPT Descriptor Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	2.50	**RUC Time**	582,643

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78815	XXX	2.44	**RUC Time**	393,487

CPT Descriptor 2 Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 48.8 %

TIME ESTIMATES (Median)	CPT Code: 74261	Key Reference CPT Code: 75635	Source of Time RUC Time
Median Pre-Service Time	5.00	10.50	
Median Intra-Service Time	40.00	45.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
edian Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**50.00**	**70.50**	
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	3.68	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.48
Urgency of medical decision making	2.91	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.64	3.95
Physical effort required	3.09	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.95	3.14
Outcome depends on the skill and judgment of physician	4.59	4.05
Estimated risk of malpractice suit with poor outcome	4.41	3.52

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.64	2.60
Intra-Service intensity/complexity	4.23	3.65
Post-Service intensity/complexity	3.14	2.95

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 ACR reviewed the survey data. The reference service code is 75635 (CTA runoff) with work value of 2.40. The 25th percentile work value for 74261 is 2.45. We believe that this value for 74261 remains high compared to the recommended physician work value for codes 74262 (25th percentile work value of 2.50) and 74263 (25th percentile work value of 2.28). The 25th percentile for 7426X1 is also high based on the modest incremental increase in physician time between 74261 and 74263. Therefore, we recommend a physician work value of 2.40, slightly less than the 25th

percentile work value, accounting for the 2 minutes of additional intra-service time compared to 74263 (38 min compared to 40 min for 74261) and modest increase in complexity between 74263 and 74261 based on the typical patient.

SERVICES REPORTED WITH MULTIPLE 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) 0067T

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

Specialty Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 134600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Gastroenterology elected not to survey 7426X1 and 7426X2. We believe that radiology would be the dominant provider, but this may change as the technique becomes more widely used.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

pecialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,232 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Gastroenterology elected not to survey 7426X1 and 7426X2.

We believe that radiology would be the dominant provider, but this may change as the technique becomes more widely used.

Specialty	Frequency 0	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. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74262 Tracking Number GG2 Specialty Society Recommended RVU: **2.50**

Global Period: XXX RUC Recommended RVU: **2.50**

CPT Descriptor: Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with abdominal discomfort, iron deficiency anemia and guaiac positive stools. Optical colonoscopy was unsuccessful due to extreme redundancy of the colon.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

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

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

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

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

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

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

Description of Pre-Service Work:

- Review the reason for the exam, any pertinent clinical history and any prior imaging studies.
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists.

Description of Intra-Service Work:

- Supervise insertion of rectal tube and instillation of room air or carbon dioxide.
- Review 2D [scout] topogram of abdomen and pelvis to ensure adequate colonic distention for each acquisition.
- Supervise acquisition of thin section, low-dose 2D CT images and review for adequacy.
- After ensuring continued adequate colonic distention, supervise acquisition of thin section, low-dose 2D CT images in the second position, typically prone, review for adequacy and instruct the technologist to acquire appropriate additional images if needed.

When an indeterminate polypoid lesion is identified, supervise administration of intravenous iodinated contrast and .rgeted re-acquisition of 2D images the colon.

- Interpret 2D post-contrast images to differentiate an enhancing soft tissue lesion from adherent stool.
- Perform interactive manipulations of 3D image datasets (volume rendered, endoluminal and/or flythrough views) with correlative multiplanar 2D reconstructions of datasets from all positions. Modify and perform additional targeted 3D reconstructions as necessary.

- Interpret both the supine and prone images of the colon (including decubitus if performed) using 2- and 3D reconstructions, including 3D endoluminal views, integrated with 2D multiplanar reformations and source images and compare to pertinent prior imaging studies.
- Dictate a report for the medical record.

Description of Post-Service Work:

- Review and sign report.
- Communicate significant results to referring physician and, when appropriate, discuss patient management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Paul Knechtges, MD		
Specialty(s):	ACR		
CPT Code:	74262		
Sample Size:	200	**Resp N:** 35	**Response:** 17.5 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**28.00**	78.00	900.00
Survey RVW:	2.38	2.50	**2.60**	2.79	4.21
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	35.00	**45.00**	50.00	70.00

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

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

Specialty Society Recommended Data

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

CPT Code:	74262	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
75635	XXX	2.40	**RUC Time**

CPT Descriptor Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	2.50	**RUC Time**	582,643

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78815	XXX	2.44	**RUC Time**	393,487

CPT Descriptor 2 Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 54.2 %

TIME ESTIMATES (Median)	**CPT Code: 74262**	**Key Reference CPT Code: 75635**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	10.50	
Median Intra-Service Time	45.00	45.00	
Median Immediate Post-service Time	7.00	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	**57.00**	**70.50**	
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	3.56	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.56
Urgency of medical decision making	3.17	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	4.11
Physical effort required	3.00	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.89	2.72
Outcome depends on the skill and judgment of physician	4.61	4.11
Estimated risk of malpractice suit with poor outcome	4.28	3.39

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.68	2.53
Intra-Service intensity/complexity	4.47	3.84
Post-Service intensity/complexity	3.00	2.84

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 ACR has reviewed the survey data. The reference service code is 75635 (CTA runoff) with work value of 2.40. We looked at the physician work values as well as the time difference between 74261, 74262, and 74263. 74261 has total time of 50 min (5, 40, 5) with recommended value of 2.40. 74262 has total time of 59 min (7, 45, 7). 7426X3 has total time of 51 min (8, 38, 5) with a recommended value of 2.28. Based on the incremental increase in the intra-service time, we believe that the 25th percentile work value of 2.50 is appropriate for 74262 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) 0067T

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

Specialty Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6432
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Gastroenterology elected not to survey 7426X1 and 7426X2. We believe that radiology would be the dominant provider, but this may change as the technique becomes more widely used.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty
Please explain the rationale for this estimate. Gastroenterology elected not to survey 7426X1 and 7426X2. We believe that radiology would be the dominant provider, but this may change as the technique becomes more widely used.

Specialty Frequency 0 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. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74263 Tracking Number GG3 Specialty Society Recommended RVU: **2.28**

Global Period: XXX RUC Recommended RVU: **2.28**

CPT Descriptor: Computed tomographic (CT) colonography, screening, including image postprocessing

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female without signs or symptoms who presents for colorectal cancer screening.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

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

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

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

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

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

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

Description of Pre-Service Work:

- Review the reason for the exam, any pertinent clinical history and any prior imaging studies.
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists.

Description of Intra-Service Work:

- Supervise insertion of rectal tube and instillation of room air or carbon dioxide.
- Review 2D [scout] topogram of abdomen and pelvis to ensure adequate colonic distention for each acquisition.
- Supervise acquisition of thin section, low-dose 2D CT images and review for adequacy.
- After ensuring continued adequate colonic distention, supervise acquisition of thin section, low-dose 2D CT images in the second position, typically prone, review for adequacy and instruct the technologist to acquire appropriate additional images if needed.
- Perform interactive manipulations of 3D image datasets (volume rendered, endoluminal and/or flythrough views) with correlative multiplanar 2D reconstructions of datasets from all positions. Modify and perform additional targeted 3^{r} reconstructions as necessary.
- Interpret both the supine and prone images of the colon (including decubitus if performed) using 2- and 3D reconstructions, including 3D endoluminal views, integrated with 2D multiplanar reformations and source images and compare to pertinent prior imaging studies.
- Dictate a report for the medical record.

Description of Post-Service Work:

- Review and sign report.
- Communicate significant results to referring physician and, when appropriate, discuss patient management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Paul Knechtges, MD, Brooks Cash, MD, Joel Brill, MD, Nicholas Nickl, MD				
Specialty(s):	ACR, AGA, ASGE				
CPT Code:	74263				
Sample Size:	301	**Resp N:**	60	**Response:** 19.9 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	19.00	**25.00**	100.00	1000.00
Survey RVW:	0.79	2.28	**2.50**	2.60	4.00
Pre-Service Evaluation Time:			**8.00**		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	5.00	30.00	**38.00**	45.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	____	99291x 99292x
Other Hospital time/visit(s):	____	99231x 99232x 99233x
Discharge Day Mgmt:	____	99238x 99239x
Office time/visit(s):	____	99211x 12x 13x 14x 15x
Prolonged Services:	____	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

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

CPT Code:	74263	**Recommended Physician Work RVU: 2.28**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**38.00**		

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

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
75635	XXX	2.40	**RUC Time**

CPT Descriptor Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
88189	XXX	2.23	**RUC Time**	127,046

CPT Descriptor 1 Flow cytometry, interpretation; 16 or more markers

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.30	**RUC Time**	3,254,499

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of 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
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 35.0 %

TIME ESTIMATES (Median)	CPT Code: 74263	Key Reference CPT Code: 75635	Source of Time RUC Time
Median Pre-Service Time	7.00	10.50	
Median Intra-Service Time	38.00	45.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**50.00**	**70.50**
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	3.35	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	4.10
Urgency of medical decision making	2.55	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	3.90
Physical effort required	2.80	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.85	3.00
Outcome depends on the skill and judgment of physician	4.80	4.10
Estimated risk of malpractice suit with poor outcome	4.25	3.50

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

Time Segments (Mean)

Pre-Service intensity/complexity	2.70	2.45
Intra-Service intensity/complexity	4.30	3.75
Post-Service intensity/complexity	3.00	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.*

ACR, AGA, and ASGE convened a consensus panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 75635 (CTA runoff) with a work value of 2.40. From the survey data the median recommended work value for code 74263 is 2.50, with times as follows: 8 min pre, 38 min intra, and 5 min post. The survey respondents indicated that code 74263 entails greater intensity and complexity than reference code 75635 for 7 of the 11 measures.

The panel reviewed the pre-time from the survey and noted that there is an additional 1 minute as compared to the standard package. We believe this additional minute is appropriate for 74263 because as a screening examination, patients may be self-referred and documentation of an appropriate physician for follow up adds additional time as compared to the typical XXX studies ordered by a physician.

The societies are recommending the 25th percentile work value of 2.28 with the median physician time of 8 min pre, 38 min intra, and 5 min post. In comparison to the reference service code, the panel noted that intra-service time was 7 minutes less; however; the intensity and complexity values indicate that 74263 is more intense. To reconcile these differences, the panel believes that the 25th percentile work value best reflects the physician work involved for code 74263.

This is supported by evaluation of several XXX non-radiology services previously valued by the RUC including 93312 and 99204. The time elements are as follows:

93312: Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

99204: Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of 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.

Code	Work value	Pre	Intra	Post	Total Time	Global
93312	2.20	15	13	15	43	XXX
99204	2.30	5	30	10	45	XXX

SERVICES REPORTED WITH MULTIPLE 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0066T

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

Specialty Radiology How often? Commonly

Specialty Gastroenterology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 396200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. In 2003, 6.47 million colonoscopies were performed and out of these, 1.981 million were screening. An assumption was made that CTC volume will equal 20 percent of optical colonoscopy. The 70/ 30 breakdown is based on the number of surveys collected from each specialty.

Specialty Radiology Frequency 277340 Percentage 70.00 %

Specialty Gastroenterology Frequency 118860 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? 62,312 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. In 2007 Medicare data estimates that CPT code G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) was billed approximately 311,562 times. An assumption was made that CTC volume will equal 20 percent of optical colonoscopy. The 70/ 30 breakdown is based on the number of surveys collected from each specialty.

Specialty Radiology Frequency 43618 Percentage 69.99 %

Specialty Gastroenterology Frequency 18694 Percentage 30.00 %

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. Non-Surgical

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

CPT Long Descriptor:
74261: Computed tomographic colonography, diagnostic, including image postprocessing; without contrast material

74262: Computed tomographic colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

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

The ACR convened a group of radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

- Greet patient and provide growing
- Provide pre-service education/ obtain consent
- Prepare room, equipment, supplies
- Prepare and position the patient
- Perform CT examination to obtain source images
- Start IV (for 74262 only)
- Assist physician during postprocessing including photography of all source and reformatted images
- Review images with physician for adequacy
- Clean room

Post-Service Clinical Labor Activities:

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

CPT Long Descriptor:
Computed tomographic colonography, screening, including image postprocessing

Sample Size: NA Response Rate: (%): NA Global Period: XXX

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:

The ACR, AGA, and ASGE convened a group of radiologists and gastroenterologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

- Greet patient and provide growing
- Provide pre-service education/ obtain consent
- Prepare room, equipment, supplies
- Prepare and position the patient
- Perform CT examination to obtain source images
- Assist physician during postprocessing including photography of all source and reformatted images
- Review images with physician for adequacy
- Clean room

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F
1				74261	74262	74263
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee	CMS	Staff	Computed tomographic colonography, diagnostic, including image postprocessing; without contrast material	Computed tomographic colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Computed tomographic colonography, screening, including image postprocessing
3	LOCATION	Code	Type	Non Facility	Non Facility	Non Facility
4	GLOBAL PERIOD			XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			91.0	101.0	91.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			91.0	101.0	91.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0
9	PRE-SERVICE					
10	**Start: Following visit when decision for surgery or procedure made**					
11	Complete pre-service diagnostic & referral forms					
12	Coordinate pre-surgery services					
13	Schedule space and equipment in facility					
14	Provide pre-service education/obtain consent					
15	Follow-up phone calls & prescriptions					
16	Other Clinical Activity (please specify)					
17	Obtain appropriate prior studies	L041B	RT			
18	**End: When patient enters office/facility for surgery/procedure**					
19	SERVICE PERIOD					
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
21	Review charts					
22	Greet patient and provide gowning	L041B	RT	3	3	3
23	Obtain vital signs					
24	Provide pre-service education/obtain consent	L041B	RT	2	2	2
25	Prepare room, equipment, supplies	L041B	RT	5	5	5
26	Setup scope (non facility setting only)					
27	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	9	9	9
28	Sedate/apply anesthesia					
29	**Intra-service**					
30	Perform CT examination to obtain source images	L041B	RT	30	35	30
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	L041B	RT	7	7	7
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					
41	Other Clinical Activity (please specify)					
42	Start IV for high volume and rate power injection	L041B	RT		5	
43	Assist physician during postprocessing including photography of all source and reformatted images	L041B	RT	30	30	30
44	Review images with physician for adequacy	L041B	RT	5	5	5
45	**End: Patient leaves office**					

	A	B	C	D	E	F
1				74261	74262	74263
2	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee**	**CMS**	**Staff**	**Computed tomographic colonography, diagnostic, including image postprocessing; without contrast material**	**Computed tomographic colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed**	**Computed tomographic colonography, screening, including image postprocessing**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
46	**POST-SERVICE Period**					
47	**Start: Patient leaves office/facility**					
48	Conduct phone calls/call in prescriptions					
49	**End: with last office visit before end of global period**					
50	**MEDICAL SUPPLIES**	**CMS**	**Unit**			
51	Gloves, sterile	SB024	pair			
52	Gloves, non-sterile	SB022	pair	1	1	1
53	Gown, patient	SB026	item	1	1	1
54	Angiocatheter 14g-24g	SC001	item		1	
55	IV tubing (extension)	SC019	item		1	
56	Needle, 18-27g	SC029	item		1	
57	Stop cock, 4-way	SC050	item		1	
58	Syringe, pressure (radiology)	SC060	item		1	
59	Swab-pad, alcohol	SJ053	item		1	
60	Sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	item		1	
61	Bandage, strip 0.75in x3 in (Bandaid)	SG021	item		1	
62	Tape, surgical paper 1in (Micropore)	SG079	inch		1	
63	Tubing kit (from EZ-EM)		item	1	1	1
64	CO2		liter	4 liters	4 liters	4 liters
65	Computer media, optical disk 2.6 gb	SK016	item	1	1	1
66	**Equipment**	**CMS Code**				
67	CT room	EL007		X	X	X
68	C02 insufflator system			X	X	X

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Cardiac MR Velocity Flow

At the February 2007 CPT Meeting, the Editorial Panel created eight new cardiac MRI codes, which were reviewed by the RUC in April 2007. In the *Final Rule* for the 2008 Medicare Physician Payment Schedule, CMS indicated that it would not cover the four of the eight new cardiac MRI services that include flow/velocity quantification. As such, the CPT Editorial Panel, at its November 2008 meeting, created one new add-on code for velocity flow and deleted the existing four services that previously included velocity flow. Specifically, the Panel created 75565, *Cardiac magnetic resonance imaging for velocity flow mapping* and deleted 75558, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification* (work RVU = 2.60), 75560, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress* (work RVU = 3.00), 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* (work RVU = 2.86), and 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* (work RVU = 3.35).

322

The specialty society presented the survey results of 79 cardiologists and radiologists for 75565. Survey respondents indicated a median work RVU of 0.50, which the specialty societies' expert panel agreed was too high. Moreover, the survey 25th percentile work RVU was 0.40, which the expert panel also agreed was too high. The expert panel noted that survey respondents indicated a key reference service 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, intra-service = 15 minutes). Given the similarity in the intensity and complexity required to perform the surveyed code and the reference service, and the difference in intra-service time between the two (10 minutes and 15 minutes, respectively), the specialties and the RUC agreed that the work RVU for 75565 should be lower than 93320.

In addition to reviewing the survey, the RUC reviewed the differentials between those codes that included flow and those that did not that had been valued by the RUC in April 2007. The RUC looked to codes 75557, *Cardiac magnetic resonance imaging for morphology and function without contrast material* (work RVU = 2.37) and 75561, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.60). The existing differential in work RVUs between 75557 (without flow) and 75558 (with flow) is 0.25. The existing differential in work RVUs between 75561

(without flow) and 75562 (with flow) is 0.26. The survey respondents indicated a median intra-service time of 10 minutes, with significant pre-service and post-service time, inconsistent with other ZZZ global period codes. The expert panel and the RUC agreed that no pre- or post-service time is required for this add-on service. In order to substantiate the survey median intra-service time, the RUC also examined the difference in intra-service time between the codes from April 2007. The difference in intra-service time between 75557 (without flow) and 75558 (with flow) is 5 minutes and the difference between 75561 (without flow) and 75562 (with flow) is 10 minutes. Given this, the specialty and the RUC agreed that the intra-service time of 10 minutes as reported by the surveyees was appropriate. **Therefore, the RUC recommends a work RVU of 0.25 and intra-service time of 10 minutes for 75565.**

Practice Expense

The RUC approved the practice expense inputs noting a reduction in the clinical staff intra-service time to 10 minutes consistent with the physician intra-service time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Cardiac magnetic imaging differs from traditional magnetic resonance imaging (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 with 75565 ~~and 75560~~ to report flow with pharmacologic wall motion stress evaluation without contrast. Use 75563 with 75565 ~~and 75564~~ to report flow with pharmacologic perfusion stress with contrast. Cardiac MRI for velocity flow mapping can be reported in conjunction with 75557, 75559, 75561, 75563. 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 the patient, see appropriate sections also. Only one procedure in the series 75557-75563 ~~75564~~ is appropriately reported per session. Only one add-on code for flow velocity can be reported per session. Cardiac computed tomography (CT) and coronary computed tomographic angiography (CTA) include the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence (if performed), as well as the two-dimensional and three-dimensional reformatted images resulting from the study, including cine review. Contrast enhanced cardiac CT and coronary CTA codes 75571-75574 include any quantitative assessment when performed as part of the same encounter. Report only one computed tomography heart service per encounter. (75552-75556 have been deleted. To report, see 75557, 75559, 75561, 75563, 75565)				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●+75565	HH1	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure) (Do not report 75557 ~~-75564~~, 75559, 75561, 75563, 75565 in conjunction with 76376, 76377) (Use 75565 in conjunction with 75557, 75559, 75561, 75563)	ZZZ	0.25
D 75558		~~Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification~~	XXX	N/A
D 75560		~~with flow/velocity quantification and stress~~	XXX	N/A
D 75562		~~Cardiac magnetic resonance imaging for morphology and function contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification~~	XXX	N/A
D 75564		~~with flow/velocity quantification and stress~~ (75558, 75560, 75562 and 75564 have been deleted. To report flow velocity, use 75565)	XXX	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75565 Tracking Number Specialty Society Recommended RVU: **0.25**

Global Period: ZZZ RUC Recommended RVU: **0.25**

CPT Descriptor: Cardiac Magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year old male presents with heart failure, enlarged cardiac silhouette on chest x-ray and an eccentric jet of aortic regurgitation on echocardiography. Patient is undergoing cardiac MRI to evaluate ventricular size and function. Flow velocity quantification is also requested.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

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

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

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

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 34%

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

Description of Pre-Service Work:

Description of Intra-Service Work: • Supervise set-up of flow quantification scan planes
- Scan using flow protocols to obtain data to quantify valve function
- Adjust the parameters to optimize data accuracy
- Analyze velocity/flow data on an independent workstation
- Calculate regurgitation fraction, gradients or shunt ratio using velocity/flow data obtained

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	Edward T. Martin, MD, James Maloney, MD, Geraldine McGinty, MD, Zeke Silva, MD		
Specialty(s):	ACC, ACR, SCMR		
CPT Code:	75565		
Sample Size:	495	**Resp N:** 79	**Response:** 15.9 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**120.00**	200.00	1000.00
Survey RVW:	0.07	0.40	**0.50**	0.88	49.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**10.00**	17.50	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	75565	**Recommended Physician Work RVU: 0.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93320	ZZZ	0.38	**RUC Time**

CPT Descriptor Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	14,308,549

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94060	XXX	0.31	**RUC Time**	1,193,603

CPT Descriptor 2 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 42 **% of respondents:** 53.1 %

TIME ESTIMATES (Median)	CPT Code: 75565	Key Reference CPT Code: 93320	Source of Time CMS Time File
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	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	**10.00**	**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	3.50	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	2.86
Urgency of medical decision making	2.98	2.93

Technical Skill/Physical Effort (Mean)

Technical skill required	4.26	3.33
Physical effort required	2.40	2.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.29	1.98
Outcome depends on the skill and judgment of physician	3.93	3.43
Estimated risk of malpractice suit with poor outcome	2.86	2.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.29	1.55
Intra-Service intensity/complexity	3.57	2.67
Post-Service intensity/complexity	3.74	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.*

his service is an add-on code used to reflect flow/velocity measurements attained through cardiac MRI. Eight new cardiac MRI codes received RUC valuation at the April 2007 RUC meeting and those values were accepted by CMS in the rulemaking process. Four of these codes included flow/velocity quantification, but these services were not covered by Medicare. As part of the coding application that established this new add-on code, the four codes that included flow/velocity (75558, 75560, 75562, 75564) were deleted.

The American College of Cardiology, American College of Radiology, and Society for Cardiovascular Magnetic Resonance convened a panel of physicians to review the results of the RUC survey on the new code. The survey was completed by 80 physicians who had performed the service an average of 120 times in the past year, so they were very familiar with the service.

In addition to reviewing the survey, the panel reviewed the differentials between those codes that included flow and those that did not that had been valued by the RUC in April 2007. After reviewing these items, the panel felt that the work value that had been recommended by the surveyees was not supported by the difference in the work RVUs between the existing codes as recommended by the RUC. The add-on service is most likely to be reported on codes 75557 and 755561. The existing differential in work RVUs between 75557 (without flow) and 75558 (with flow) is 0.25. The existing differential in work RVUs between 75561 (without flow) and 75562 (with flow) is 0.26. While this work value is below even the 25th percentile work RVU recommendation of the survey, the panel did not believe that this change in coding structure should increase the value for the service and that the surveys conducted in 2007 accurately reflected the level of work.

Examining the issue of the reported time, the survey respondents reported significant pre and post service time. Add-on codes do not routinely include pre or post service time, so the panel recommends that only intraservice time be assigned to this code. The survey respondents reported a median of 10 minutes of intraservice time. The panel also examined the difference in intraservice time that was found between the codes from April 2007. The difference in intraservice time between 75557 (without flow) and 75558 (with flow) is 5 minutes and the difference between 75561 (without flow) and 75562 (with flow) is 10 minutes. The panel felt that the intraservice time of 10 minutes as reported by the surveyees was reflective of the service time.

The panel also reviewed these recommendations in coordination with the key reference service. The key reference service of 93320 has a work value of 0.38 and an intraservice time of 15 minutes. The median intraservice time as reported by the surveyees was 10 minutes, 2/3 of the 15 minutes in the reference service. If the work value for 93320 was to be similarly cut by 1/3, it would equal 0.25, the same as the work value established by examining the differences between the existing codes reported with and without flow.

The panel recommends a work RVU of 0.25 and an intraservice time of 10 minutes with no pre 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75558, 75560, 75562 and 75564 were bundled codes used to report the base cardiac MRI service in addition to the flow/velocity quantification. As part of the application to the CPT Editorial Panel for this add-on code, those codes were proposed for deletion.

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? Sometimes

Specialty Radiology How often? Sometimes

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. This estimate is based on the estimate provided in the original application for the cardiac MR codes in 2007, which was in turn based on expert opinion and a review of claims data. Because the new Cardiac MR codes were introduced in 2008, there is no claims data from those codes that can be used yet.

Specialty Cardiology Frequency 12000 Percentage 60.00 %

Specialty Radiology Frequency 8000 Percentage 40.00 %

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. This estimate is based on the estimate provided in the original application for the cardiac MR codes in 2007, which was in turn based on expert opinion and a review of claims data. Because the new Cardiac MR codes were introduced in 2008, there is no claims data from those codes that can be used yet.

Specialty Cardiology Frequency 3000 Percentage 60.00 %

Specialty Radiology Frequency 2000 Percentage 40.00 %

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

CPT Code:75565

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

CPT Long Descriptor: Cardiac Magnetic resonance imaging for velocity flow mapping (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:

The ACC and ACR convened a group of cardiologists and radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

The MR Tech will review charts and previous studies performed to determine flow.

The MR Tech ensures proper position of patient for the flow study. A test study is performed to confirm optimum timing for the diagnostic study. The source scans are obtained using breath hold and adjusting velocity flow setting. Multiple set-ups and acquisitions are being done to ensure the images are satisfactory.

Post-Service Clinical Labor Activities:

	A	B	C	D	E
1				75565	
2	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee Recommendation**	**CMS Code**	**Staff Type**	**Cardiac Magnetic resonance imaging for velocity flow mapping**	
3	**LOCATION**			**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**ZZZ**	**ZZZ**
5	**TOTAL CLINICAL LABOR TIME**			**10.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**10.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms				
12	Coordinate pre-surgery services				
13	Schedule space and equipment in facility	L047A	MR Tech		
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 - echo data	L047A	MR Tech		
22	Greet patient and provide gowning	L047A	MR Tech		
23	Obtain vital signs	L047A	MR Tech		
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies	L047A	MR Tech		
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L047A	MR Tech		
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Pre scan planning and test scan; obtain scan using breath hold and adjusting velocity flow setting	L047A	MR Tech	**10**	
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff	L047A	MR Tech		
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions	L047A	MR Tech		
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	L047A	MR Tech		
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**
54	Other Activity (please specify)				
55	**End: with last office visit before end of global period**				
56	**MEDICAL SUPPLIES**		**Unit**		
57	no supplies				
58	**Equipment**				
59	Room, MR	EL008		**10**	
60	computer workstation, 3D reconstruction CT-MR	ED104		**10**	
61	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		**10**	
62	IV Infusion Pump	EQ032		**10**	
63	Cardiac Coil			**10**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Coronary Computed Tomographic Angiography

In October 2008 the CPT Editorial Panel deleted eight Category III codes and created four new codes to describe the evolution of performing cardiac and coronary computed tomography for specific clinical scenarios.

75571 ***Computed tomography, heart without contrast material, with quantitative evaluation of coronary calcium***
The RUC reviewed the specialty societies' recommended data and agreed that the physician time (5 minutes pre-, 10 minutes intra- and 5 minutes post-service time) recommended by the specialties accurately reflected the service. However, the RUC did not agree that the survey values were reflective of the work performed, noting that even the survey 25th percentile work RVU of 0.70 was too high. The RUC compared 75571 to code 75962 *Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation* (work RVU = 0.54 and 12 minutes total physician time) and determined that 75571 required slightly more work. The RUC also compared 75571 to similar services 95903 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study* (work RVU = 0.60 and 8 minutes pre-, 10 minutes intra- and 10 minutes post-service time) and 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface* (work RVU=0.60 and 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time). The RUC determined that a work RVU of 0.58 for 75571 appropriately accounts for the work required to perform this service. Additionally, CPT codes 75962, 95903 and 11000 have similar work RVUs and physician time compared to surveyed code 75571. **The RUC recommends a work RVU of 0.58 for CPT code 75571.**

75572 ***Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)***
The specialty society provided a very detailed description of the work included in 75572, which includes evaluation of cardiac structure, morphology, venous structures, 3D reconstruction, contrast and administration of a beta-blocker. The RUC agreed with the specialty society that the survey median work RVU of 2.25 is too high, while the survey 25th percentile work RVU of 1.25 does not account for the extent of the work performed. The RUC reviewed several comparable reference services: 72196, *Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)* (work RVU = 1.72, pre-service = 15, intra-service = 20, post-service = 10); 71551, *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)* (work RVU = 1.73, pre-service = 10, intra-service = 25, post-service = 10); 70498, *Computed tomographic angiography,*

neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing (work RVU = 1.75, pre-service = 7, intra-service = 20, post-service = 10); and 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 8, intra-service = 20, post-service = 10). The RUC agreed that these services are appropriate references and a work RVU of 1.75, which is half way between the survey 25th percentile and median, maintains rank order within this family of services. **The RUC recommends a work RVU of 1.75 for 75572.**

75573 ***Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)***

The RUC reviewed the pre-service time for 75573 and agreed with the societies' recommended additional pre-service time compared to the other services within this family, as the physician has several pre-operative tests to review and as the service is typically performed on a child, the physician must answer many questions posed by the patient and the patient's family. The RUC agreed that the service time, 15 minutes of pre-service time, 30 minutes of intra-service time and 15 minutes of post-service time, accurately reflect the service. After reviewing the physician time, the RUC compared the surveyed code to the reference code, 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* (Work RVU=3.35). As the surveyed code has significantly less total service time as compared to the reference code (60 and 85 minutes, respectively) and the surveyed code is performed on a child rather than an adult as in the reference code, the RUC agreed that a work RVU of 2.55, the surveyed 25th percentile, accurately reflects the work associated with 75573. **The RUC recommends a work RVU of 2.55 for 75573.**

337

75574 ***Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)***

The RUC reviewed the specialty society physician time and work RVU data recommended data for code 75574, 10 minutes pre-service, 30 minutes intra-service and 10 minutes post-service time. The specialty society recommended a lower pre-and post-service time than the surveyed time by reducing 5 minutes from both the pre- and post-service time because the respondents indicated higher times than are typical when compared to similar services. The RUC determined that 30 minutes of intra-service time, as indicated by the survey respondents, was appropriate to account for the time required to perform this service (issue multiple beta blockers, contrast media two times, calculate fractions, calculate cardiac output, etc). The RUC then compared 75574 to code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material* (work RVU = 2.35, 10 minutes pre-time, 40 minutes intra-time and 10 minutes post-time) plus 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each*

additional sequential intravenous push of a new substance/drug (work RVU = 0.10) (2.35 + 0.10 = 2.45) to support a work RVU of 2.40 for code 75574, which is less than the survey 25th percentile. **The RUC recommends a work RVU of 2.40 and 10 minutes pre-, 30 minutes intra- and 10 minutes immediate post-service time for code 75574.**

Practice Expense
The RUC reviewed the practice expense inputs for all four services within the family and confirmed the clinical labor time proposed by the Practice Expense Subcommittee. The RUC discussed the equipment and recommends that the uninterruptible power supply be deleted as it is an indirect expense. The tilt table was also deleted from equipment. The RUC reviewed the appropriate time that the CT scanner will be in use and recommends the following time (activities = lines 78 and 79):

75571, 16 slice CT = 15 minutes
75572, 64 slice CT = 26 minutes
75573, 64 slice CT = 37 minutes
75574, 64 slice CT = 43 minutes

338

The computer workstation and all software are equal to (line 88 - reconstruct images at selected intervals…)

75571 = 12 minutes
75572 = 21 minutes
75573 = 23 minutes
75574 = 29 minutes

New Technology
The RUC recommends that these services be added to the New Technology List.

PLI Codes
The RUC recommends the PLI for the technical component of each service be 0.00. The RUC recommends following PLI crosswalks:

75571 should be crosswalked to 78472
75572 should be crosswalked to 70498

75573 should be crosswalked to 75558
75574 should be crosswalked to 75557

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 0144T		~~Computed tomography, heart, without contrast material, including image postprocessing and quantitative evaluation of coronary calcium~~ ~~(Do not report 0144T in conjunction with 0145T-0151T)~~		N/A
D 0145T		~~Computed tomography, heart, with contrast material(s), including noncontrast images, if performed, cardiac gating and 3D image postprocessing; cardiac structure and morphology~~ ~~(For cardiac structure and morphology in congenital heart disease, use 0150T)~~		N/A
D 0146T		~~computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium~~		N/A
D 0147T		~~computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium~~ ~~(Do not report 0147T in conjunction with 0144T)~~		N/A
D 0148T		~~cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium~~		N/A

339

D 0149T		~~cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium~~ ~~(Do not report 0149T in conjunction with 0144T)~~		N/A
D 0150T		~~cardiac structure and morphology in congenital heart disease~~		N/A
D 0151T		~~Computed tomography, heart, with contrast material(s), including noncontrast images, if performed, cardiac gating and 3D image postprocessing, function evaluation (left and right ventricular function, ejection fraction and segmental wall motion) (List separately in addition to code for primary procedure)~~ (0144T-0151T have deleted. To report see 75571-75574)		N/A
71250		Computed tomography, thorax; without contrast material	XXX	1.16 (No Change)
71270		*without contrast material, followed by contrast material(s) and further sections* *(To report 3D rendering, see 76376, 76377)* (For cardiac computed tomography of the heart, see ~~0144T-0151T~~75571-75574)	XXX	1.38 (No Change)
71275		*Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* (For coronary artery computed tomographic angiography including calcification score and/or cardiac morphology, use ~~0146T-0149T~~75574)	XXX	1.92 (No Change)

340

Cardiac computed tomography (CT) and coronary computed tomographic angiography (CTA) include the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence (if performed), as well as the two-dimensional and three-dimensional reformatted images resulting from the study, including cine review. Contrast enhanced cardiac CT and coronary CTA codes 75571-75574 include any quantitative assessment when performed as part of the same encounter. Report only one computed tomography heart service per encounter.

●75571	K1	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	XXX	0.58
●75572	K2	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	XXX	1.75
●75573	K3	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	XXX	2.55
●75574	K4	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	XXX	2.40
76376		3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation (Use 76376 in conjunction with code(s) for base imaging procedure(s)) (Do not report 76376 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 75557-75564, 75571-75574, 76377, 78000-78999, 0066T, 0067T, ~~0144T-0151T,~~ 0159T)	XXX	0.20 (No Change)

341

76377		requiring image postprocessing on an independent workstation (Do not report 76377 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75557-75564, 75571-75574, 75635, 76376, 78000-78999, 0066T, 0067T, ~~0144T-0151T,~~ 0159T)	XXX	0.79 (No Change)

342

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:75571 Tracking Number K1 Specialty Society Recommended RVU: **0.70**

Global Period: XXX RUC Recommended RVU: **0.58**

CPT Descriptor: Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year-old male presents for evaluation. He is asymptomatic. His family history is significant for coronary disease with his father having suffered a myocardial infarction at the age of 58. A lipid profile is as follows: Total cholesterol 245 mg/dl, LDL cholesterol 156 mg/dl, HDL cholesterol 34 mg/dl, and triglycerides 190 mg/dl. Framingham risk assessment calculates a 10% risk of coronary disease over the following 10 years. A calcium score is ordered to help support the initiation of therapy with lipid-lowering agents.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

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

Description of Pre-Service Work:
- Review medical records and any applicable prior imaging studies
- Review protocol for examination with technologists and other clinical staff
- Review indication for study and appropriateness

Description of Intra-Service Work: Describe the procedure to the patient and obtain informed consent where applicable. Review scout views of area to be imaged, axial images of the heart for adequacy prior to transfer to the workstation, and post-processed images for the presence of calcified coronary atherosclerosis. Quantify coronary artery calcium using dedicated software that determines the "Agatston Score", the calcified volume and the mass of calcium. Next, compare the amount of calcium detected for each individual patient to databases of population data stratified for age, gender and ethnicity, and interpret source images for correlation with the post-processed images and for the presence of coexistin disease. Finally, compare and correlate with pertinent available prior studies and create report for the medical record

Description of Post-Service Work:
- Review and sign the final report for the patient's medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	James Maloney MD (ACC), Vinay Malhotra, MD (ACC), Geraldine McGinty, MD (ACR), Pamela Woodard, MD (ACR)				
Specialty(s):	Cardiology and Radiology (ACC, ACR, ASNC, SCAI, SCCT)				
CPT Code:	75571				
Sample Size:	713	**Resp N:**	81	**Response:** 11.3 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**200.00**	500.00	5000.00
Survey RVW:	0.25	0.70	**1.01**	1.18	3.60
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**10.00**	15.00	60.00

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

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

Specialty Society Recommended Data

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

CPT Code:	75571	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

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

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
71250	XXX	1.6	**RUC Time**

CPT Descriptor Computed tomography, thorax; without contrast material

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20600	000	0.66	**RUC Time**	387,625

CPT Descriptor 1 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
65205	000	0.71	**RUC Time**	25,076

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival superficial

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 49 **% of respondents:** 60.4 %

TIME ESTIMATES (Median)	CPT Code: 75571	Key Reference CPT Code: 71250	Source of Time RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	10.00	22.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**20.00**	**22.00**	
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	2.57	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.69	2.94
Urgency of medical decision making	2.18	2.92

Technical Skill/Physical Effort (Mean)

Technical skill required	2.76	2.94
Physical effort required	1.94	2.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.92	2.29
Outcome depends on the skill and judgment of physician	2.67	3.18
Estimated risk of malpractice suit with poor outcome	2.53	3.16

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.14	2.20
Intra-Service intensity/complexity	2.76	2.82
Post-Service intensity/complexity	2.69	2.57

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.*

ACC, ACR, ASNC, SCAI, and SCCT convened a panel of physicians that included a number of physicians familiar with this service to review the RUC survey data. The group noted that nearly half of the respondents chose code 71250 as the key reference service for the procedure. In examining the differences between these codes, the panel noted that code 71250 has 22 minutes of total time and a work RVU of 1.6. The median response from the survey participants

indicated that the new service would take approximately 20 minutes total time, with half of that time devoted to the intraservice period. The median RVU recommendation for the new service was 1.01.

The panel noted that there was less time demanded for this new service and that the respondents indicated that it wa considerably less intense than the key reference code of 71250. The reference service was noted to be of particula higher intensity in mental effort and judgment. Although the survey respondents appeared to adjust for this reduced intensity in their recommendation of a 1.01 work RVU, the panel felt that the work RVU was still too high for this service. The panel determined that it would be more appropriate to recommend a work RVU of 0.70, which is identical to the 25th percentile response on the survey. The panel felt that the time inputs reflected on the survey of 5 minutes of pre-time, 10 minutes of intra-service time, and 5 minutes of post time were 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) This service was previously reported using CPT Category III code 0144T.

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? Sometimes

Specialty Radiology How often? Sometimes

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. It is difficult to estimate the number of times that this service will be reported outside of the Medicare population, but it is expected that the specialty mix for the provision of these services will be similar to that seen in the Medicare use of the existing temporary codes.

Specialty Cardiology Frequency 15000 Percentage 75.00 %

Specialty Radiology Frequency 5000 Percentage 25.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on the reporting patterns of the CPT Category III code 0144T that had previously been used to track this service. This is roughly equal to the number of these service reported in the Medicare population in 2007, when the service was covered in much of the country.

Specialty Cardiology Frequency 2200 Percentage 73.33 %

Specialty Radiology Frequency 800 Percentage 26.66 %

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. 77003

ndicate 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:75572 Tracking Number K2 Specialty Society Recommended RVU: **1.75**

Global Period: XXX RUC Recommended RVU: **1.75**

CPT Descriptor: Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year-old female is seen for treatment of atrial fibrillation. A 48 hour monitor now shows her to be in atrial fibrillation ~12% of the time. RF ablation is planned to isolate the pulmonary veins and eliminate the focus of atrial fibrillation. Cardiac CT is ordered by the electrophysiologist to identify the number, location, and morphology of the pulmonary veins as they enter the left atrium, the contours of the endoluminal surface of the left atrium, and the location of the esophagus in relation to the pulmonary veins.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

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

Description of Pre-Service Work:

- Review medical record and any applicable prior imaging studies
- Review indication for study and appropriateness
- Review patients symptoms if present
- Review previous cardiac surgical reports
- Review medication list
- Review previous drug allergies and potential contrast allergy
- Determine heart rhythm and need for pharmacological intervention
- Assess baseline heart rate and the need for pharmacological intervention to lower the heart rate
- Prescribe pharmacological intervention to lower the heart rate if necessary
- Review protocol for examination with technologists and other clinical staff

Description of Intra-Service Work: Describe the procedure to the patient and obtain informed consent where applicable. Review scout views of area to be imaged and non-contrast CT images to localize the vascular phase sequence and to screen those patients who are not candidates for the arterial phase component of the study. Supervise administration of

low- or iso-osmolar contrast material. Administer IV medication to lower heart rate when necessary and administer IV medication to control heart rhythm when necessary. Manage pacemaker function and rate when applicable. Review the arterial phase CT images to ensure adequate anatomic coverage. Prescribe and review venous phase images as necessary. Create two-dimensional reconstructions of the vasculature, interpret, and annotate. Create three-dimensional reconstructions of the vasculature and associated myocardium and adjust the projection of the three-dimensional reconstructions to optimize visualization of anatomy or pathology. Interpret the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence, as well as the two-dimensional and three-dimensional reformatted images resulting from the study, including cine review. Compare study results to all pertinent available prior studies and dictate report for medical record.

Description of Post-Service Work:

- Manage complications related to IV, contrast agent, or medications given at the time of the study
- Review and sign the final report for the patient's medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	James Maloney MD (ACC), Vinay Malhotra, MD (ACC), Geraldine McGinty, MD (ACR), Pamela Woodard, MD (ACR)				
Specialty(s):	Cardiology and Radiology (ACC, ACR, ASNC, SCAI, SCCT)				
CPT Code:	75572				
Sample Size:	713	**Resp N:**	73	**Response:** 10.2 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	30.00	**100.00**	200.00	1200.00
Survey RVW:	0.35	1.25	**2.25**	2.80	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	15.00	**20.00**	30.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	____	99291x 99292x
Other Hospital time/visit(s):	____	99231x 99232x 99233x
Discharge Day Mgmt:	____	99238x 99239x
Office time/visit(s):	____	99211x 12x 13x 14x 15x
Prolonged Services:	____	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

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

CPT Code:	75572	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**7.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
71260	XXX	1.24	**RUC Time**

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

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	66,597

CPT Descriptor 1 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99375	XXX	1.73	**RUC Time**	0

CPT Descriptor 2 Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary, or equivalent environment; 30 minutes or more

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 23.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 75572**	**Key Reference CPT Code: 71260**	**Source of Time RUC Time**
Median Pre-Service Time	10.00	3.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	10.00	5.00	
Median Critical Care Time	0.0	0.00	
edian 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**	**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	3.59	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.35
Urgency of medical decision making	3.12	3.29

Technical Skill/Physical Effort (Mean)

Technical skill required	3.76	3.47
Physical effort required	2.24	2.06

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	3.65	3.65
Estimated risk of malpractice suit with poor outcome	3.47	3.65

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.65	2.35
Intra-Service intensity/complexity	3.47	3.18
Post-Service intensity/complexity	2.94	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 Valı Recommendations for the appropriate formula and format.*

ACC, ACR, ASNC, SCAI, and SCCT convened a panel of physicians that included a number of physicians familiar with this service to review the RUC survey data. The panel noted that there was extraordinary variation among the work RVUs recommended by the survey respondents, with the 25th percentile recommended work RVU at 1.25 and the

75th percentile recommended work RVU at 2.80. The panel also noted that the key reference service 71260 (CT thorax, with contrast) was chosen by only 23% of the respondents.

In comparing the new service to the key reference codes, the panel noted that the new service was moderately more intense than the key reference service in most cases. The key reference service of 71260 has a work value of 1.24 and an intraservice time of 15 minutes. The median intraservice time as reported by the surveyees for the new service was 20 minutes. The panel felt that the slightly higher intensity and longer time for the service of the new code did not justify the median RVU of 2.25, an entire work RVU greater than the key reference service. However, the panel felt that the 25th percentile response of 1.25 did not adequately account for the additional time required of the new code, which is 5 minutes longer or the slightly higher intensity. The panel recommended that the work RVU of 1.75 would be most appropriate for this service, reflecting the midpoint between the 25th percentile and the median.

The panel felt that a work RVU of 1.75 and an intraservice time of 20 minutes appropriately reflected the level of work required for the service and compared well to other codes. The panel thought that the code compared well with code 70496, CT angiography of the head with contrast. This code, which was RUC valued in 2000, also has 20 minute of intraservice time and a work value of 1.75. Although this code was not selected as a reference service by the majority of respondents, this may be explained by the fact that 75% of the survey respondents were cardiologists, who do not frequently perform this service. The panel also looked at code 71275, CT angiography of the chest (non coronary) as an additional comparison code. That code, which was RUC valued in 2001, is valued at 1.92 with 30 minutes of intraservice time. Although the intraservice time for the new service is only 20 minutes (2/3 of 71275), it would likely have a higher intensity than a non-coronary CT of the chest.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was previously reported using the CPT Category III code 0145T as well as elements of other codes 0148T, 0149T, and 0151T. The codes were reorganized for the Category I code proposal and this reorganization was accepted by the CPT Editorial Panel.

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? Sometimes

Specialty Radiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 35000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is difficult to predict how often this newly developing technology will be used in the general population. The estimated specialty mix is based on that reflected in the specialty mix for the existing Category III codes.

Specialty Cardiology Frequency 26000 Percentage 74.28 %

Specialty Radiology Frequency 9000 Percentage 25.71 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 18,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on a review of the 2007 claims data for the existing Medicare

Specialty Cardiology Frequency 13500 Percentage 75.00 %

Specialty Radiology Frequency 4500 Percentage 25.00 %

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. Crosswalk to code 70498 as it has a similar work RVU. The TC PLI RVU should be 0.00.

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:75573 Tracking Number K3 Specialty Society Recommended RVU: **2.55**

Global Period: XXX RUC Recommended RVU: **2.55**

CPT Descriptor: Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image post processing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 12-year-old male presents for evaluation. As an infant he underwent bilateral modified Blalock-Taussig shunts for Tetralogy of Fallot with pulmonary atresia. Subsequent to that he underwent total repair which included an aortic homograft Rastelli conduit from right ventricle to the pulmonary arteries. Echocardiography reveals pulmonary pressures that are 65% of systemic pressures. There is minimal Rastelli valve stenosis but marked insufficiency and right ventricular enlargement. Bilateral peripheral pulmonary artery stenosis is suspected but branch pulmonary arteries are not visualized on echocardiography. The patient is referred for cardiac CT to: 1) measure RV volume to determine whether he is a candidate for pulmonic valve replacement, and 2) define branch pulmonary arteries to rule out significant peripheral pulmonary stenosis.

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

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 26%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 13%

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

Description of Pre-Service Work:

- Review medical record and any applicable prior imaging studies
- Review indication for study and appropriateness
- Review patient's symptoms if present
- Review previous cardiac surgical reports
- Review medication list
- Review previous drug allergies and potential contrast allergy
- Determine heart rhythm and need for pharmacological intervention
- Assess baseline heart rate and the need for pharmacological intervention
- Prescribe pharmacological intervention to lower the heart rate if necessary
- Review protocol for examination with technologists and other clinical staff

Description of Intra-Service Work: Describe the procedure to the patient and parents and obtain informed consent where applicable. Review scout views of area to be imaged and non-contrast CT images to localize the vascular phase sequence. Supervise administration of low- or iso-osmolar contrast material. Appropriately modify contrast protocol ensure adequate cardiac chamber opacification. Review the enhanced phase CT images to ensure adequate anatomic coverage. Prescribe and review delayed images as necessary. Evaluate multiphasic reconstructions for identification of end-systole and end-diastole and determine boundary between myocardium and blood pool. Quantitatively determine ventricular volumes of the heart using dedicated cardiac function analysis software available on the workstation. Quantitatively determine right ventricular volumes of the heart. Calculate ejection fraction, stroke volume and/or cardiac output of both left and right ventricles. Create two-dimensional reconstructions of the heart and adjacent structures, interpret, and annotate. Create three-dimensional reconstructions of the heart and adjacent structures. Adjust the projection of the three-dimensional reconstructions to optimize visualization of anatomy or pathology. Interpret the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence, as well as the two-dimensional and three-dimensional reformatted images resulting from the study, including cine review. Compare to all pertinent available prior studies.

Description of Post-Service Work:

- Manage complications related to IV, contrast agent, or medications given at the time of the study
- Review and sign the final report for the patient's medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	James Maloney MD (ACC), Vinay Malhotra, MD (ACC), Geraldine McGinty, MD (ACR), Pamela Woodard, MD (ACR)				
Specialty(s):	Cardiology and Radiology (ACC, ACR, ASNC, SCAI, SCCT)				
CPT Code:	75573				
Sample Size:	713	**Resp N:**	69	**Response:** 9.6 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**20.00**	40.00	300.00
Survey RVW:	1.00	2.55	**3.00**	3.35	5.50
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	25.00	**30.00**	45.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	75573	**Recommended Physician Work RVU: 2.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**7.00**	**8.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
75564	XXX	3.35	RUC Time

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 and 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	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.56	RUC Time	3,285,523

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99479	XXX	2.50	RUC Time	0

CPT Descriptor 2 Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 36.2 %

TIME ESTIMATES (Median)	CPT Code: 75573	Key Reference CPT Code: 75564	Source of Time RUC Time
Median Pre-Service Time	15.00	15.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**60.00**	**85.00**
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	4.80	4.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.72	4.36
Urgency of medical decision making	4.00	3.80

Technical Skill/Physical Effort (Mean)

Technical skill required	4.68	4.52
Physical effort required	3.24	3.24

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.68	3.48
Outcome depends on the skill and judgment of physician	4.76	4.52
Estimated risk of malpractice suit with poor outcome	4.08	3.84

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.20	4.00
Intra-Service intensity/complexity	4.32	4.32
Post-Service intensity/complexity	4.48	4.16

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.*

ACC, ACR, ASNC, SCAI, and SCCT convened a panel of physicians that included a number of physicians familiar with this service to review the RUC survey data. The panel noted that 36 percent of survey respondents selected 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) as the reference service for the co 75564 was valued by the RUC in 2007. However, the respondents reported that the new service was only moderate more intense than the key reference service and had 25 minutes less intraservice time than the key reference service. The respondents did indicate that the new service had some greater intensity in some areas, particularly in the outcome depending on the judgment of the physician. The panel felt that the 25th percentile work RVU as reported by those surveyed of 2.55 more appropriately reflected the work level for this service. The panel recommended this 2.55 work RVUs with an intraservice time 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: No

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service was reported using code 0150T.

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? Rarely

Specialty Radiology 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. It is difficult to predict how often this service will be provided in the general population.

Specialty Cardiology Frequency 2200 Percentage 73.33 %

Specialty Radiology Frequency 800 Percentage 26.66 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. There were 35 services reported using the previously existing T codes in 2007. The service will be infrequently reported in the Medicare population because it is most commonly reported for the pediatric population.

Specialty Cardiology Frequency 150 Percentage 75.00 %

Specialty Radiology Frequency 50 Percentage 25.00 %

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. Code 75558 should be used as a crosswalk as it has a similar work RVU. The TC PLI RVU should be 0.00.

ndicate 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:75574 Tracking Number K4 Specialty Society Recommended RVU: **2.50**

Global Period: XXX RUC Recommended RVU: **2.40**

CPT Descriptor: Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post-processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female presents for evaluation and possible treatment for chest pain. The pain is described as a retrosternal tightness that radiates to her left shoulder. Her physician determines that she is at intermediate risk for coronary artery disease. Stress evaluations in the past have been non-diagnostic. She is referred for cardiac CT angiography for evaluation of her coronary anatomy and for left ventricular function.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

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

Description of Pre-Service Work:

- Review medical record and any applicable prior imaging studies
- Review indication for study and appropriateness
- Review patients symptoms if present
- Review previous cardiac surgical reports
- Review medication list
- Review previous drug allergies and potential contrast allergy
- Determine heart rhythm and need for pharmacological intervention
- Assess baseline heart rate and the need for pharmacological intervention to lower
- Prescribe pharmacological intervention to lower the heart rate if necessary
- Review protocol for examination with technologists and other clinical staff

Description of Intra-Service Work: Describe the procedure to the patient and obtain informed consent where applicable. Review scout views of area to be imaged, axial images of the heart for adequacy prior to transfer to the workstation, and view post-processed images for the presence of calcified coronary atherosclerosis. Coronary artery calcium is quantified using dedicated software that determines the "Agatston Score", the calcified volume and the mass of calcium.

Next, the amount of calcium detected is compared to databases of population data stratified for age and gender. Review non-contrast CT images to localize the vascular phase sequence and to screen those patients who are not candidates for the arterial phase component of the study. Administer IV medication to lower heart rate when necessary and administer IV medication to control heart rhythm when necessary. Manage pacemaker function and rate when applicable. Supervise administration of low- or iso-osmolar contrast material. Appropriately modify contrast protocol to ensure adequate cardiac chamber opacification. Evaluate multiphasic reconstructions for identification of end-systole and end-diastole and determine boundary between myocardium and blood pool. Quantitatively determine ventricular volumes of the heart using dedicated cardiac function analysis software available on the workstation. Calculate ejection fraction, stroke volume and/or cardiac output of both left and right ventricles. Review the arterial phase CT images to ensure adequate anatomic coverage. Prescribe and review delayed images as necessary. Prescribe and review venous phase images as necessary. Create two-dimensional reconstructions of the vasculature, interpret, and annotate. Create three-dimensional reconstructions of the vasculature and associated myocardium. Adjust the projection of the three-dimensional reconstructions to optimize visualization of anatomy or pathology. Interpret the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence, as well as the two-dimensional and three-dimensional reformatted images resulting from the study, including cine review. Compare to all pertinent available prior studies.

Description of Post-Service Work:

- Manage complications related to IV, contrast agent, or medications given at the time of the study
- Review and sign the final report for the patient's medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	James Maloney MD (ACC), Vinay Malhotra, MD (ACC), Geraldine McGinty, MD (ACR), Pamela Woodard, MD (ACR)				
Specialty(s):	Cardiology and Radiology (ACC, ACR, ASNC, SCAI, SCCT)				
CPT Code:	75574				
Sample Size:	713	**Resp N:**	75	**Response:** 10.5 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	100.00	**200.00**	500.00	3000.00
Survey RVW:	0.90	2.50	**2.90**	3.35	4.75
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	20.00	**30.00**	45.00	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	75574	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**7.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
75562	XXX	2.82	**RUC Time**

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

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99222	XXX	2.56	**RUC Time**	3,285,523

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99479	XXX	2.50	**RUC Time**	0

CPT Descriptor 2 Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)	CPT Code: 75574	Key Reference CPT Code: 75562	Source of Time RUC Time
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	30.00	55.00	
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	**50.00**	**75.00**
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	4.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.94
Urgency of medical decision making	4.06	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	4.53	4.53
Physical effort required	2.65	2.53

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.65
Outcome depends on the skill and judgment of physician	4.53	4.47
Estimated risk of malpractice suit with poor outcome	3.82	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.41	3.35
Intra-Service intensity/complexity	4.24	4.47
Post-Service intensity/complexity	3.53	3.41

Additional Rationale

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

ACC, ACR, ASNC, SCAI, and SCCT convened a panel of physicians that included a number of physicians familiar with this service to review the RUC survey data. The panel noted that approximately 23% of respondents chose code

75562 (Cardiac MRI for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification) as the reference service code. This code has a work RVU of 2.86 and has an intraservice time of 55 minutes. The respondents reported that the intensity of the services was similar, higher in some categories and lower in others. The panel felt that respondents may have misallocated the time portions to pre and post service time as opposed to intraservice time. The median reported pre and post times were 15 minutes, both far higher than established standards for similar procedures. However, the panel believes that those surveyed understand how long it takes to perform the complete service and may have assigned work that is in fact part of the intraservice time to the pre and post times. The panel therefore recommends that the median total time of 60 minutes be retained, but the time be altered so that 40 minutes are assigned as intraservice time and 10 minutes each are assigned to pre and post times.

The panel believed that even with this change in time allocations, the recommended work RVU from the survey participants was still too high in comparison to the key reference service code and other services commonly reported by both cardiologists and radiologists. The panel felt that the 25% percentile recommended work RVU of 2.5 more appropriately reflected the level of work that is appropriate 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) This service was previously reported using Category III codes 0146T and 0147T and add-on code 0151T. These codes were deleted and reorganized in conversion to Category I codes.

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

Specialty Cardiology How often? Sometimes

Specialty Radiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 50000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is difficult to report how often this code will be reported due to rapidly developing technology and evidence. The specialty mix is based on 2007 Medicare claims data.

Specialty Cardiology Frequency 37000 Percentage 74.00 %

Specialty Radiology Frequency 13000 Percentage 26.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimated is based on a review of the 2007 Medicare claims data for the existing Category III codes that were used to report this service.

Specialty Cardiology Frequency 23000 Percentage 76.66 %

Specialty Radiology Frequency 7000 Percentage 23.33 %

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. Crosswalk to code 75557 as it has a similar work RVU. The TC PLI RVU should be 0.00.

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

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

CPT Long Descriptor: **Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium**

Sample Size: Consensus Panel Response Rate: (%):_____ Global Period: XXX

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

The ACC and ACR convened a group of cardiologists and radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff person will complete required pre-service diagnostic & referral forms, obtain Radiology Quality Initiative (RQI) number - required for CT scans and provide pre-service education to the patient on what to expect for the procedure and obtain consent.

Intra-Service Clinical Labor Activities:

The clinical staff person will review charts, ensures RQI has been obtained, greets the patient and provides a gown, prepare room and supplies and prepares patient for study.

The technologist positions the patient on the CT table, noncontrast CT images are then obtained to localize the appropriate area to be scanned in the vascular phase. A test bolus is injected to confirm optimum timing for the diagnostic scan. The source axial images are obtained. Performance of limited reconstruction assess each phase for motion artifact. With the physician's assistance, 2-D reconstructions of the vasculature are created.

The technologist finds and reviews appropriate previous studies and assembles them for physician's review

Post-Service Clinical Labor Activities:

The clinical staff will also call in any prescriptions and coordinate follow-up care.

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

CPT Long Descriptor: **Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)**

Sample Size: Consensus Panel Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The ACC and ACR convened a group of cardiologists and radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff person will complete required pre-service diagnostic & referral forms, obtain Radiology Quality Initiative (RQI) number - required for CT scans, provide pre-service education to the patient on what to expect for the procedure and obtain consent.

The RN will complete the required prescription for beta-blocker, calcium channel blocker, and/or acetylcysteine and provide to patient prior to procedure.

Intra-Service Clinical Labor Activities:

The clinical staff person will review charts, ensure RQI number has been obtained, greets the patient and provides a gown, prepare room and supplies and prepares patient for study.

The RN meets patient and questions them regarding contrast allergies. The RN explains the feelings the patient will experience during contrast injection and the importance of remaining motionless. An IV is started. The IV must be adequate to accommodate high volume rapid power injection and thus must be angiocath. The RN supervises the contrast injection. The patient is counseled regarding post contrast thrombophlebitis and delayed reactions to contrast. The technologist positions patient for study. Noncontrast CT images are obtained to localize the appropriate area to be scanned in the vascular phase. A test bolus is injected to confirm optimum timing for the diagnostic scan. The source axial images are obtained. Arterial phase images are technically reviewed for appropriate anatomic coverage. The patient is assisted from the CT table when it has been ascertained that the original images are satisfactory. The technologist finds and reviews appropriate previous studies and assembles them for physician's review. With the physicians's assistance, 2-D reconstructions of the vasculature are created. 3-D reconstructions of the vasculature are also created. Creation of 2-D and 3-D reconstructions typically require more than one attempt for optimum visualization of anatomy and pathology.

Post-Service Clinical Labor Activities: The clinical staff will also call in any prescriptions and coordinate follow-up care.

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

CPT Long Descriptor: **Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image post processing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)**

Sample Size: Consensus Panel Response Rate: (%):_____ Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The ACC and ACR convened a group of cardiologists and radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff person will complete required pre-service diagnostic & referral forms, obtain RQI number, provide pre-service education to the patient on what to expect for the procedure and obtain consent.

The RN will complete the required prescription for beta-blocker, calcium channel blocker, and/or acetylcysteine and provide to patient prior to procedure.

Intra-Service Clinical Labor Activities:

The clinical staff person will review charts, ensure RQI number has been obtained, greets the patient and provides a gown, prepare room and supplies and prepares patient for study.

The RN meets patient and questions them regarding contrast allergies.

The RN explains the feelings the patient will experience during contrast injection and the importance of remaining motionless. After the technologist positions the patient on the CT table, an IV is started. The IV must be adequate to accommodate high volume rapid power injection and thus must be angiocath. The RN administers metoprolol or diltiazem as needed for coronary CTAs. The RN administers sublingual nitroglycerin for coronary CTAs. During that time the RN is also assessing EKG tracing for stability, regularity and reposition if necessary.

The technologist positions patient on CT table for study. The technician hooks up power injector to IV cannula and the contrast injection. The patient is counseled regarding post contrast thrombophlebitis and delayed reactions to contrast. Noncontrast CT images are obtained to localize the appropriate area to be scanned in the vascular phase. A test bolus is injected to confirm optimum timing for the diagnostic scan. The source axial images are obtained. Arterial phase images are technically reviewed for appropriate anatomic coverage. The patient is assisted from the CT table when it has been ascertained that the original images are satisfactory.

The technologist finds and reviews appropriate previous studies and assembles them for physician's review. With the physicians's assistance, 2-D reconstructions of the vasculature are created. 3-D reconstructions of the vasculature are also created. Creation of 2-D and 3-D reconstructions typically require more than one attempt for optimum visualization of anatomy and pathology.

Post-Service Clinical Labor Activities:

The clinical staff will also call in any prescriptions and coordinate follow-up care.

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

CPT Long Descriptor: **Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post-processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)**

Sample Size: Consensus Panel Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The ACC and ACR convened a group of cardiologists and radiologists from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe the clinical activities of your staff:
Pre-Service Clinical Labor Activities:
The clinical staff person will complete required pre-service diagnostic & referral forms, obtain Radiology Quality Initiative (RQI) number - required for CT scans and provide pre-service education to the patient on what to expect for the procedure and obtain consent.
The RN will complete the required prescription for beta-blocker, calcium channel blocker, and/or acetylcysteine and provide to patient prior to procedure.

Intra-Service Clinical Labor Activities:
The clinical staff person will review charts - obtain RQI number, greets the patient and provides a gown, prepare room and supplies and prepares patient for study.
The RN meets patient and questions them regarding contrast allergies.
The RN explains the feelings the patient will experience during contrast injection and the importance of remaining motionless. After the technologist positions the patient on the CT table, an IV is started. The IV must be adequate to accommodate high volume rapid power injection and thus must be angiocath. The RN administers metoprolol or diltiazem as needed for coronary CTAs. The RN administers sublingual nitroglycerin for coronary CTAs. The technician hooks up power injector to IV cannula and the contrast injection. The patient is counseled regarding post contrast thrombophlebitis and delayed reactions to contrast. During that time the RN is also assessing EKG tracing for stability, regularity and reposition if necessary. The RN obtains blood pressure pre-CT, post-CT and during exam as necessary. The patient is assisted from the CT table when it has been ascertained that the original images are satisfactory.

The technologist finds and reviews appropriate previous studies and assembles them for physician's review. With the physicians's assistance, 2-D reconstructions of the vasculature are created. 3-D reconstructions of the vasculature are also created. Creation of 2-D and 3-D reconstructions typically require more than one attempt for optimum visualization of anatomy and pathology.

Post-Service Clinical Labor Activities:
The clinical staff will call in any prescriptions and coordinate follow-up care.

	A	B	C	D	E	F	G	H	I	J	K
1				75571		75572		75573		75574	
2	AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium		Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)		Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image post processing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)		Descriptor Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post-processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	
3	LOCATION	Code	Type	Facility		Non Facility		Non Facility		Non Facility	
4	GLOBAL PERIOD										
5	TOTAL CLINICAL LABOR TIME			41.0		88.0		106.0		116.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME			2.0		4.0		4.0		4.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			39.0		84.0		102.0		112.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0		0.0		0.0		0.0	
9	TOTAL RN/LPN/MTA TIME			10.0		12.0		18.0		18.0	
10	TOTAL RN TIME			4.0		29.0		34.0		36.0	
11	TOTAL CT TECHNOLOGIST TIME			27.0		47.0		54.0		62.0	
12	PRE-SERVICE										
13	Start: Following visit when decision for surgery or procedure made										
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2		2		2		2	
15	Coordinate pre-surgery services										
16	Schedule space and equipment in facility										
17	Provide pre-service education/obtain consent										
18	Follow-up phone calls & prescriptions	L051A	RN			2		2		2	
19	Other Clinical Activity (please specify)										
20	End: When patient enters office/facility for surgery/procedure										
21	SERVICE PERIOD										
22	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
23	Obtain appropriate prior studies	L046A	CT Tech	2		2		2		2	
24	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3		3		3	
25	Obtain vital signs	L051A	RN	3		3		3		3	
26	Provide pre-service education/obtain consent	L051A	RN	1		2		2		2	
27	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2		2	
28	Setup scope (non facility setting only)										
29	Prepare and position patient/ monitor patient/ set up IV	L046A	CT Tech	1		2		2		2	
30	Sedate/apply anesthesia										
32	Intra-service										
33	Place EKG leads, monitor EKG gating, contrast injection, and patient vital signs during procedure	L051A	RN			22		27		29	
34	Perform CT exam to obtain source images	L046A	CT Tech	12		22		27		29	
35	Post-Service										
36	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA					6		6	
37	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3		3	
38	Reconstruct images at selected intervals, reformat and assist physician reviewing images, send images to workstation and storage system	L046A	CT Tech	12		21		23		29	
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptio	L037D	RN/LPN/MTA			2		2		2	
40	Discharg nagement										

	A	B	C	D	E	F	G	H	I	J	K
1				75571		75572		75573		75574	
2	AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium		Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)		Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image post processing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)		Descriptor Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post-processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	
3	LOCATION	Code	Type	Facility		Non Facility		Non Facility		Non Facility	
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: None*										
54	*Total Office Visit Time*			0	0	0	0	0	0	0	0
55	Other Activity (please specify)										
56	**End: with last office visit before end of global period**										
57	MEDICAL SUPPLIES		Units								
58	pack, minimum multi-specialty visit	SA048		1		1		1		1	
59	alcohol swab	SJ053				4		4		4	
60	cannula, anterior chamber, 18-27g	SD145				1		1		1	
62	10-20 ml syringe	SC051				1		1		1	
63	18 g needle	SC027				3		3		3	
64	sodium chloride 0.9% flush syringe	SH065				2		2		2	
66	EKG electrodes	SJ019		3		3		3		3	
67	electrode conductive gel	SJ020		1		1		1		1	
68	IV Tubing extension	SC019				1		1		1	
70	Sublingual nitroglycerin spray									1	
71	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068				1		1		1	
72	bandage, strip 0.75in x 3in (Bandaid)	SG021				1		1		1	
73	gauze, non-sterile 2in x 2in	SG050				1		1		1	
76	computer media, optical disk 2.6 gb	SK016		0.1		0.1		0.1		0.1	
77	Equipment		Units								
78	**Computed Tomography Scanner - 16 slice**	EL007		15							
79	64 slice CT scanner	New				26		37		43	
80	Coronary CTA Post processing software	New						23		29	
81	Calcium Scoring Software	New		12						29	
82	Left Ventricular Function software	New				21		23		29	
84	Power Injector for CT Contrast	New				26		37		43	
85	Monitoring equipment	New				26		37		43	
86	Contrast Warmer	New				2		2		2	
87	electrophysiology, pulmonary vein processing software	New				21					
88	computer workstation, 3D reconstruction CT-MR	ED014		12		21		23		29	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Multi-Leaf Collimator IMRT Device Use

In October 2008 the CPT Editorial Panel created a new code to describe the design and construction of multi-leaf collimator (MLC) intensity modulated radiation therapy (IMRT) device use. Previously, patients treated with IMRT were reported under code 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU = 1.24). However, the technical component expense portion was incorrectly captured in the practice expense of code 77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*, not under code 77334.

The RUC reviewed 77338 *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction, per IMRT plan*. The specialty societies indicated that 77338 captures the appropriate physician work and practice expense, specifically the medical physics and medical dosimetry time and equipment that was not in code 77418. The specialty societies indicated that the physician work starts at the time following treatment plan 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU = 7.99). Multiple fluence patterns are generated and the physician must review the plan and make the proper adjustments to the MLC device prior to treatment to protect normal surrounding tissue (i.e., bladder, anterior rectal wall, etc). The physician selects a range set of segments for each device, fine tunes and deletes small segments to eliminate any treatment inefficiency and adjusts the dose profile again for every beam (typically 9 beams). The specialty society indicated and the RUC agreed that the physician work required to adjust each beam is approximately 13 minutes per beam (total intra-service time = 115 minutes). The specialty society indicated that each fluence map is different for every beam so each requires approximately the same amount of time, in other words, each additional beam would not require less time nor would the physician become more efficient.

The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 4.29 appropriately accounted for the work required to perform this service. The RUC compared 77338 to reference service 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* (work RVU = 4.56 and 98 minutes intra-service time) and determined that although the reference code requires less physician time, it is slightly more intense and complex to perform than 77338. Additionally, the RUC compared 77338 to the physician work that is currently reported as 77334 *Treatment devices, design and construction; complex (irregular blocks, special*

shields, compensators, wedges, molds or casts) (work RVU = 1.24, intra-service time = 35 minutes), which is reported per field. The IWPUT for CPT 77334 (0.035) when compared to the survey physician time for 77338 (115 minutes) supports the survey 25th percentile RVU recommended by the specialty society (0.035 x 115 = 4.03). **The RUC recommends the survey 25th percentile work RVU of 4.29 for code 77338.**

Practice Expense

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

PLI

The RUC recommends the PLI for 77338 be crosswalked to 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* and a 0.00 PLI for the technical component only.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●77338	J1	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction, per IMRT plan (For immobilization in IMRT treatment, use 77332-77334) (Do not report 77338 more than once per IMRT plan) (Do not report 77338 in conjunction with 0073T, compensator based IMRT)	XXX	4.29

383

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77338 Tracking Number J1 Specialty Society Recommended RVU: **4.29**

Global Period: XXX RUC Recommended RVU: **4.29**

CPT Descriptor: Multi-leaf collimater (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction

(For immobilization in IMRT treatment, use 77332-77334)

(Do not use with 0073T, compensator based IMRT)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following clinical treatment planning (77261-77263), simulation (77280-77290), and creation of the treatment isodose for a nine field IMRT plan (77301), a 65 year old man with stage T2a, N0, M0 adenocarcinoma of the prostate who will be treated with IMRT presents for design and construction of the nine custom MLC devices required for delivery of the IMRT treatment.

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

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

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

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

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: Physician work on the multi-leaf collimator (MLC) treatment device begins after the intensity modulated plan (77301) has been generated. This plan will have achieved satisfactory compliance with the prescribed tumor and normal tissue dose specifications by modulating the intensity of the radiation beam through separate beam positions/angles (typically 9). This dose modulation per beam angle is displayed as fluence maps. The physician work for the IMRT device is associated with the work of converting the fluence map for each beam into a series of small segments shaped by multileaf collimators and the ongoing revision and adjustments to these devices to assure that the final device shape achieves the necessary dose modulation from each beam.

The physician reviews with the dosimetrist the combination of beam angles and MLC segments that have been generated to produce the intended cross-sectional beam intensity profile. For each modulated beam, the dosimetrist operates the planning software to provide a digitally reconstructed radiograph that represents the maximum aperture of each MLC-

shaped field. For each individual beam, the MD and dosimetrist consider the component segments (typically around 20 to 30 per beam), taking into consideration both the pertinent anatomic relationships (e.g., avoidance of unintended entrance or exit dose to a structure remote from the tumor that was not accounted for in the initial planning) and practical considerations (e.g. avoidance of the need for the patient to be immobilized for an excessive length of time or othe obvious inefficiency in treatment delivery e.g. removal of very small segments which contribute minimal dose). This repeated for each beam angle. The entire set of MLC segment combinations (the IMRT Treatment Device) has to be evaluated by the radiation oncologist, since modification of any one might require compensatory modification of the others to achieve the required fluence.

As modifications occur, the physician reviews these with the physicist and then the dosimetrist, who recalculates the desired dose distribution based on the modified MLC patterns. The final device is then generated and shaped using the MLC shaper and uploaded onto the information system platform.

After the final device is uploaded on the information system the physician reviews each device on the information system for accurate transfer of information and electronically approves the composite MLC device and authorizes its release to the treatment machine for use throughout the specified course of therapy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Michael Kuettel, MD, MBA, PhD and Najeeb Mohideen, MD					
Specialty(s):	Radiation Oncology					
CPT Code:	77338					
Sample Size:	500	**Resp N:**	66	**Response:** 13.2 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	57.00	**120.00**	300.00	714.00
Survey RVW:	0.70	4.29	**8.12**	11.16	16.35
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	81.00	105.00	**115.00**	135.00	300.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	77338	**Recommended Physician Work RVU: 4.29**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**115.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77334	XXX	1.24	**RUC Time**

CPT Descriptor Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45380	000	4.43	**RUC Time**	737,302

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	3.52	**RUC Time**	271,044

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 37.8 %

TIME ESTIMATES (Median)	CPT Code: 77338	Key Reference CPT Code: 77334	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	115.00	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	**115.00**	**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	4.16	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.84
Urgency of medical decision making	3.64	3.08

Technical Skill/Physical Effort (Mean)

Technical skill required	4.72	3.80
Physical effort required	3.44	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.76	4.12
Outcome depends on the skill and judgment of physician	4.76	4.04
Estimated risk of malpractice suit with poor outcome	4.40	3.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.08	3.68
Intra-Service intensity/complexity	4.52	3.64
Post-Service intensity/complexity	3.64	3.12

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.*

ASTRO's consensus panel carefully considered survey data, current coding conventions, IWPUT and recommends a value of 4.29 RVUs for CPT code 77338.

The work described by this new CPT code is currently billed with CPT 77334, billed per field (9).

CPT code 77334 (recently RUC reviewed/surveyed) currently has:
35 minutes of time
RVU of 1.24
IWPUT of 0.035

This new CPT code will be billed once per IMRT plan, not per field. An additional question was added to our survey to query our survey respondents regarding the typical number of treatment fields. The median number of treatment fields was nine (9).

The median time for the new CPT code 77338 is 115 minutes. That would represent approximately 13 minutes per treatment field. The consensus panel felt that time was appropriate.

When taking the 115 minutes of time for the new CPT code 77338, multiplied by the IWPUT for CPT code 77334 (0.035) the result is 4.03. The result 4.03 is very similar to our 25th percentile survey data of 4.29.

The results for an RVU recommendation of 4.29 will result in an IWPUT of 0.037, very similar to the IWPUT for CPT code 77334 (0.035).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code may be reported on same date of service as other codes depending on the pace and flow of the process of care as the patient is prepared to receive IMRT. The code 77301 describes the work of IMRT computer plan development, but typically takes many days to complete. As a matter of convenience, reporting this code on the same day as this new code could occur. The work and practice expense for these codes are separate and distinct.

3.

4. CPT Code	Global Period	Work RVUs	Pre Time	Intra Time	Post Time	Total Time
5. 77301	XXX	7.99	30	131	35	196

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 77334 times the number of treatment fields

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? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 117000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that for the Medicare population in 2006, CPT® code 77301, Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications, was billed approximately 66,600 times. The 2007 Medicare data estimates that CPT code 77301 was billed approximately 78,000 times. The overall number of services for 77301 in a one year period is estimated to be 117,000.

Specialty Radiation Oncology Frequency 117000 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? 78,000 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 for the Medicare population in 2006, CPT® code 77301, Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications, was billed approximately 66,600 times. The 2007 Medicare data estimates that CPT code 77301 was billed approximately 78,000 times.

Specialty Radiation Oncology Frequency 78000 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. Use code 77295 as a crosswalk as it has a similar work RVU. Recommend 0.00 TC only PLI RVUs.

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

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

CPT Long Descriptor: Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction

(For immobilization in IMRT treatment, use 77332-77334)
(Do not use with 0073T, compensator based IMRT)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
ASTRO developed these PE recommendations by Consensus Panel. The Panel had several radiation oncologists and medical physicists. The Panel reviewed the RUC physician work survey data carefully. The group also reviewed the CPEP inputs for several other radiation oncology codes billed for IMRT patients. As requested, two of these CPT codes (77334 and 77418) appear on the PEAC spreadsheet to serve as a reference to the PEAC. Finally, the Panel also conducted several "time motion" studies to develop and finalize these PE recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: NONE

Intra-Service Clinical Labor Activities:
The dosimetrist/medical physicist loads the IMRT plan with associated fluence patterns. The dosimetrist/medical physicist reviews the fluence patterns from the IMRT plans and then constructs the MLC motion pattern to produce the desired fluence or reviews and adjusts the MLC position and segment number constraints. The MLC position set is then created using the radiation treatment planning (RTP) system and/or MLC shaper system. The dosimetrist/medical physicist then modifies individual leaf positions to reduce or increase dose as necessary. Repeat for each of the 9 fields. Dose is recalculated based on modified patterns is necessary.

The medical physicist will then review each resultant MLC segment, digitally overlaid on the region of interest, for conformality and appropriateness of position. The medical physicist will modify individual leaf positions to remove inappropriate MLC leaf positions and review all segments to confirm an appropriate minimum number of monitor units per segment based on leaf speed and maximum leaf travel. This process is repeated for all 9 fields. After all changes are made, the medical physicist operates the software that recalculates the resultant MLC driven fluence and reviews the effect on the final dose distribution. The process is then repeated for both the initial and any separate boost IMRT segments.

The dosimetrist formats and prints the final MLC pattern map for entry into the patient's chart. The dosimetrist then uploads into the record and verify software that controls the linear accelerator's treatment delivery performance the information that defines each beam's MLC pattern of segments, confirming that each set of independent jaw positions and leaf positions are accurately transferred and repeating for each field

Post-Service Clinical Labor Activities: NONE

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**77338**	
2	**Meeting Date: February 2009**	**CMS Code**	**Staff Type**	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), desigr and construction	
3	**LOCATION**			**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**118.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**118.0**	**0.0**
8		L107A	Dos/MP	***90.0***	
9		L152A	MP	***10.0***	
10		L063A	Dos	***18.0***	
11	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
12	**PRE-SERVICE**				
13	**Start: Following visit when decision for surgery or procedure made**				
20	**End: When patient enters office/facility for surgery/procedure**				
21	**SERVICE PERIOD**				
22	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
23	Review charts				
24	*Evaluate fluence patterns, create MLC pattern, review and modify the MLC position and segment number constraints. Repeat for each field*	L107A	Dos/MP	45	
25	*Review each resultant MLC segment, overlayed on the region of interest for conformality and appropriateness of position. Modify individual leaf positions to remove inappropriate MLC leaf positions. Repeat for each field. Review all segments for minimum number of Monitor Units based on leaf speed, and maximum leaf travel.*	L107A	Dos/MP	45	
26	*Review resultant MLC driven fluence and review the effect on the dose distribution*	L152A	MP	10	
27	*Create final device on MLC shaper, format and print the final mlc segment fluence map. Upload into record and verify software that controls the linear accelerator's treatment delivery performance, confirming each set of independent jaw postions and leaf positions are accurately transferred. Repeat for each field*	L063A	Dos	18	
28	**Post-Service**				
29	Monitor pt. following service/check tubes, monitors, drains				
30	Clean room/equipment by physician staff				
31	Clean Scope				
32	Clean Surgical Instrument Package				
33	Complete diagnostic forms, lab & X-ray requisitions				
34	Review/read X-ray, lab, and pathology reports				
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
36	Discharge day management				
37	Other Clinical Activity (please specify)				
38	**End: Patient leaves office**				
39	**POST-SERVICE Period**				
40	**Start: Patient leaves office/facility**				
41	Conduct phone calls/call in prescriptions	L037D	N/LPN/MTA		
42	*Office visits: NONE*				
51	Other Activity (please specify)				
52	**End: with last office visit before end of global period**				
53	**MEDICAL SUPPLIES**		**Unit**		
54	paper, laser printing (each sheet)	SK057		9	
55	**EQUIPMENT**				
56	treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)	ED033		100	
57	computer system, record and verify	ED011		18	
58	computer, desktop, w-monitor	ED021		118	
59	computer, server	ED022		118	
60	printer, laser, paper	ED032		9	
61	MLC Shaper			18	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Tissue Examination for Molecular Studies

The CPT Editorial Panel created two CPT codes to report tissue examination and preparation procedures, which have become necessary to avoid contamination with other tissue or cell types that may cause false-positive results in certain molecular diagnostic procedures. These codes will be used to report services that need to be performed prior to ancillary diagnostic testing currently applicable to molecular studies. One example of the use of these codes is for the evaluation of sentinel lymph node biopsies requiring molecular analysis.

The RUC reviewed the surveyed data and expressed concern about the low sample size for both of these new codes. The specialty societies explained that they would consider their utilization estimate of 1,000 to be a small number of assays for a laboratory procedure. They explained that when specialized laboratory tests are performed only 1,000 to 3,000 times per year there is not a large number of laboratories doing them because most laboratories cannot afford the specialized equipment. Therefore, there is not a large number of providers for these services. The specialty society contacted all providers of this service and requested them to complete a survey. The data presented to the RUC is the data collected from these few providers. The RUC determined that based on this explanation provided by specialty society, the survey was valid.

394

88387 Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)

The RUC reviewed the survey data for 88387 as compared to the key reference code 88381 *Microdissection (ie, sample preparation of microscopically identified target); manual* (Work RVU=1.18) and noted that the intra-service time for surveyed code was less than for the reference code, 20 minutes and 30 minutes, respectively. Further, the RUC compared the surveyed code to another reference code, MPC code 29075 *Application, cast; elbow to finger (short arm)* (Work RVU=0.77) and noted that the surveyed code has less total service time as compared to this reference code, 20 minutes and 25 minutes, respectively. In addition, the RUC compared the intensity/complexity measures of 88387 to its reference code 88381 and determined that the reference code required more technical skill and physical effort and the same mental effort and judgment to perform as compared to the surveyed code. Based on these

comparisons, the RUC agreed with the specialty societies' recommended value of 0.62 RVUs which is the survey's 25th percentile. **The RUC recommends 0.62 Work RVUs for 88387.**

88388 Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)

The RUC reviewed the survey data for 88388 as compared to the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73) and noted that the intra-service time for surveyed code was less than for the reference code, 12 minutes and 20 minutes, respectively. Further, the RUC compared the surveyed code to another reference code, 77071 *Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated* (Work RVU=0.41) and noted that the surveyed code has similar total service time as compared to this reference code, 12 minutes and 11 minutes, respectively. In addition, the RUC compared the intensity/complexity measures of 88388 to its reference code 88334 and determined that the reference code required more technical skill, physical and mental effort and judgment to perform as compared to the surveyed code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 0.45 RVUs which is the 25th percentile. **The RUC recommends 0.45 Work RVUs for 88388.**

395

New Technology List:
As there are now so few laboratories performing this service and the number of respondents were so low, the RUC agreed with the specialty societies' recommendation that these codes should be placed on the New Technology List.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies with the substitution of an impervious gown instead of a staff lab coat.

PLI Crosswalk:
As the reference codes used for both of these surveyed codes were not similarly valued, the RUC requested a different code for the PLI crosswalk. The specialty society recommends CPT code 88329 *Pathology consultation during surgery;* (Work RVU=0.67) be the crosswalk for 88387 and 88318 *Determinative histochemistry to identify chemical components (eg, copper, zinc)* (Work RVU=0.42) be the crosswalk for 88388. The RUC agreed with these new PLI crosswalks and deemed them to be more appropriate as they were similarly valued to the recommended values of the surveyed codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●88387	II1	Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node) (Do not use 88387 for tissue preparation for microbiologic cultures or flow cytometric studies) (Do not use 88387 in conjunction with 88388, 88329-88334)	XXX	0.62
●+88388	II2	in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure) (Use 88388 in conjunction with 88329-88334) (Do not use 88387 or 88388 for tissue preparation for microbiologic cultures or flow cytometric studies)	ZZZ	0.45

396

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88387 Tracking Number II1 Specialty Society Recommended RVU: **0.62**

Global Period: XXX RUC Recommended RVU: **0.62**

CPT Descriptor: Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)
(Do not use 88387 for tissue preparation for microbiologic cultures or flow cytometric studies)

(Do not use 88387 in conjunction with 88388, 88329-88334)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A woman has the diagnosis of breast cancer and the surgeon performs a "sentinel lymph node biopsy."

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

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

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

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

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: The pathologist receives the specimen fresh and uses sterile technique and careful dissection to examine for nodal tissue. The pathologist finds a 1.0 cm. lymph node and carefully dissects it from the surrounding fat. Because molecular studies may be done on the lymph node tissue, special precautions are taken for the handling and processing of the nodal tissue. Each lymph node is handled on a sterile surface to avoid contamination with breast tissue or primary tumor that can yield false positive assay results on subsequent molecular studies. If more than one sentinel node is obtained, these are also processed separately to avoid a positive node contaminating a negative node. The pathologist then sections cleaned nodal tissue and does not see tissue suspicious for cancer. The node is parsed by the pathologist into subparts each approximately 2 mm in thickness. To further assess the node, alternating 2 mm subparts (in total one half the node) are tested using a molecular assay that targets a marker specific to breast tissue First, the pathologist labels the nodes with the patient's identification number and with the node number. This is done fo all sentinel nodes while keeping the tissue from each node in separate containers. Next, the tissue is carefully prepared for molecular analysis.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Dr. Jonathan Myles, MD				
Specialty(s):	College of American Pathologist				
CPT Code:	88387				
Sample Size:	18	**Resp N:**	11	**Response:** 61.1 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	8.00	13.50	**20.00**	112.50	150.00
Survey RVW:	0.35	0.62	**1.18**	1.20	1.25
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	9.00	10.00	**10.00**	13.50	15.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	88387	**Recommended Physician Work RVU: 0.62**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88381	XXX	1.18	**RUC Time**

CPT Descriptor Microdissection (ie, sample preparation of microscopically identified target); 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	Work RVU	Time Source	Most Recent Medicare Utilization
11056	000	0.00	**RUC Time**	1,404,799

CPT Descriptor 1 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29075	000	0.77	**RUC Time**	69,576

CPT Descriptor 2 Application, cast; elbow to finger (short arm)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 54.5 %

TIME ESTIMATES (Median)

	CPT Code: 88387	**Key Reference CPT Code:** 88381	**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	2.33	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.50
Urgency of medical decision making	2.67	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	2.00	2.33
Physical effort required	1.17	1.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.83	2.50
Outcome depends on the skill and judgment of physician	2.00	2.17
Estimated risk of malpractice suit with poor outcome	2.50	2.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.83	1.67
Intra-Service intensity/complexity	2.00	2.67
Post-Service intensity/complexity	2.00	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.*

ollowing the survey, the CAP determined that an Expert Panel was needed to further evaluate the data. The data were eviewed by an Expert Panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and included representatives from the general and academic pathology practice settings. The Panel also included a molecular pathologist who actively performs the surveyed service, since this CPT code represents new technology and this service is not currently performed by most general pathologists.

The Expert Panel recommends the RVW value of 0.62.

The Panel took these steps in reaching their conclusion:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of 8838X1 to the reference service 883 *Microdissection (ie, sample preparation of microscopically identified target); manual* and,
3) Compared other services/procedures on the MPC List to the recommended RVW and time of 8838X1

Review of Survey Results

The Expert Panel felt the survey respondents fairly estimated the physician work time of 20 minutes, but that the survey median RVW of 1.18 was too high. Code 8838X1 has approximately the same intensity/complexity as the reference service code 88381 *Microdissection (ie, sample preparation of microscopically identified target); manual* but with ten fewer minutes. The Panel's expert verified that the time of 20 minutes was correct for 8838X1, and that the intensity and complexity overall was about the same as that of the reference service. The Panel also looked at other services/procedures with the same total time as the new code, and felt the 25% survey value of 0.62 RVW was 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) No

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.
Please explain the rationale for this estimate. Information provided by Veridex, Johnson and Johnson

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?
3,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Information provided by Veridex, Johnson and Johnson

Specialty Pathology	Frequency 3000	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? No

If no, please select another crosswalk and provide a brief rationale. 88329 as more similarly valued

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:88388 Tracking Number II2 Specialty Society Recommended RVU: **0.45**

Global Period: ZZZ RUC Recommended RVU: **0.45**

CPT Descriptor: Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid - based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

(Use 88388 in conjunction with 88329-88334)

(Do not use 88387 or 88388 for tissue preparation for microbiologic cultures or flow cytometric studies)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A woman has the diagnosis of breast cancer and the surgeon performs a "sentinel lymph node biopsy" and requests a frozen section or touch imprint in addition to further analytic studies.

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

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

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

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

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

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

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist receives the specimen fresh. Because molecular studies will need to be performed on this specimen, the pathologist cannot use the typical frozen section protocol when initiating examination of the tissue.
Instead, the pathologist prepares the dissection area by using a sterile dissection field. This means the use of a sterile cutting board. The pathologist uses sterile technique and careful dissection to examine for nodal tissue. The pathologist finds a 1.0 cm. lymph node and carefully dissects it from the surrounding fat. Because molecular studies may be done on the lymph node tissue, special precautions are taken for the handling and processing of the nodal tissue. Each lymph node is handled on a sterile surface to avoid contamination with breast tissue or primary tumor that can yield false positive assay results on subsequent molecular studies. If more than one sentinel node is obtained, these are also processed separately (each on its own dissection board) to avoid a positive node contaminating a negative node.
The pathologist then sections cleaned nodal tissue and does not see tissue suspicious for cancer. The node is parsed by the pathologist into even numbers of subparts of approximately 2 mm in thickness.

At this point the pathologist performs a frozen section or touch imprint and finds no malignant cells.
Because no malignant cells were found by either frozen section (or touch imprint cytology), the pathologist returns to the node(s). Next, the tissue is carefully prepared for molecular analysis.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Dr. Jonathan Myles, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	88388				
Sample Size:	14	**Resp N:**	8	**Response:** 57.1 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	9.50	**22.50**	64.50	150.00
Survey RVW:	0.35	0.68	**1.19**	1.20	1.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	3.00	10.00	**12.50**	16.75	25.00

Immediate Post Service-Time:	**5.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	88388	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**12.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88334	XXX	0.73	**RUC Time**

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	1,988,003

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,519,141

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, 4-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 88388**	**Key Reference CPT Code: 88334**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	12.00	20.00	
'edian Immediate Post-service Time	0.00	0.00	
.edian 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	**12.00**	**20.00**
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	1.50	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.50	2.25
Urgency of medical decision making	2.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.25	3.00
Physical effort required	1.75	1.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.25	2.25
Outcome depends on the skill and judgment of physician	2.25	3.00
Estimated risk of malpractice suit with poor outcome	1.75	2.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.75	2.25
Intra-Service intensity/complexity	2.00	3.00
Post-Service intensity/complexity	2.00	2.25

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used a 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 CAP determined that an Expert Panel was needed to further evaluate the data. The data were reviewed by an Expert Panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and included representatives from the general and academic pathology practice settings. The Panel also included a molecular pathologist who actively performs the surveyed service, since this CPT code represents new technology and this service is not currently performed by most general pathologists.

The Expert Panel recommends the RVW value of 0.45.

The Panel took these steps in reaching their conclusions:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of +88388 to the reference service 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* and,
3) Compared other services/procedures on the MPC List to the recommended RVW and time of +88388

Review of Survey Results

The Expert Panel upon review of the raw survey data suspected that some of the survey respondents may have included some of the work time of performing the touch prep or frozen section into the total time for the surveyed code. The molecular pathologist indicated that she had included a portion of the frozen section time into the total time for +88388. The Panel reduced the total minutes to 12.5, by eliminating the pre- and post-time.

After reducing the total work time of +88388 down by 46%, the Panel then considered the appropriate work RVW. One half of the median survey RVW (0.59) was considered, but the Panel felt this value was too high since the intensity/complexity of +88388 was less than that of the reference service 88334. The Key MPC Comparison codes were reviewed in terms of both total time and intensity/complexity compared to this new code. Based on this comparison, the Panel agreed that an RVW value of 0.45 is most appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) Currently not reported

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

Specialty 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.
Please explain the rationale for this estimate. Estimate provided by Veridex, Johnson and Johnson

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? 3,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Estimate provided by Veridex, Johnson and Johnson

Specialty Pathology Frequency 3000 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? No

If no, please select another crosswalk and provide a brief rationale. 88318 as more similarly valued

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

CPT Code:_88387, 88388_____

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

CPT Long Descriptor:

88387 Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)

(Do not use 88387 for tissue preparation for microbiologic cultures or flow cytometric studies)

(Do not use 88387 in conjunction with 88388, 88329-88334)

+88388 Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)

(Use 88388 in conjunction with 88329-88334)

(Do not use 88387 or 88388 for tissue preparation for microbiologic cultures or flow cytometric studies)

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 and representatives from the general and academic pathology practice settings. Molecular pathologists who actively perform the services were also consulted during the data development.

See Excel spreadsheet for labor, supplies and equipment detail.

	A	B	C	D	E	F	G
2	TAB 12			88387		88388	
3	Meeting Date: April 2009 revised PERC Meeting			Code Descriptor: Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)		Code Descriptor: Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	LO33A	Labtech	4		4	
7	SUBTOTAL CLINICAL LABOR PER STAFF TYPE	LO33A	Labtech	0		0	
8	TOTAL PRE-SERV CLINICAL LABOR TIME PER STAFF TYPE	LO33A	Labtech	3		3	
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF	LO33A	Labtech	0		0	
10	TOTAL POST-SERV CLINICAL LABOR TIME	LO33A	Labtech	1		1	
11	PRE-SERVICE PERIOD						
12	Start: When containers/requisitions prepared for physician						
13							
14	Prepare specimen containers/preload fixative/label containers/distributre requisition form(s) to physician	LO33A		2		2	
15	Accession specimen/prepare for examination, assemble slides						
16	Perform screening function (where applicable)						
17	Prepare room. Replenish supplies.	LO33A		1		1	
18	Other Clinical Activity (please specify):						
19	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.)						
20	End: When specimen is ready for examination by pathologist						
21	SERVICE PERIOD						
22	Start: When specimen is ready for examination by pathologist						
23	Assemble and deliver slides with paperwork to pathologists for H&E examination and target selection						
24	Slides and paperwork delivered to the laboratory after target selection						
25	Deparaffination of unstained slides						
26	Examination of unstained stains to verify and visualize targets; mark with pen						
27	Collect and label tubes for target						
28	Decontamination of workspace and dissecting scope						
29	Prepare Laser instrument, quality control and maintenance functions						
30	Microdissect each unstained slide sequentially while reviewing H and E stained slide						
31	Document procedure in logs and place tubes in storage until extraction						
32	Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)						
33	Prepare specimen for automated processing						
34	Process specimen for slide preparation (includes staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)						
35	Assemble and deliver slides with paperwork to pathologists						
36	Clean room/equipment whille performing service						
37	Coordinate care						
38	Other Activity (please specify)						
39	End: When specimen examination by pathologist is complete						
40	POST-SERVICE Period						
41	Start: When specimen examination by pathologist is complete						

	A	B	C	D	E	F	G
2	**TAB 12**			**88387**		**88388**	
3	**Meeting Date: April 2009 revised PERC Meeting**			**Code Descriptor: Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)**		**Code Descriptor: Macroscopic examination, dissection and preparation of tissue for microscopic analytical s (eg, nucleic acid – base molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
42	Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)						
43	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	LO33A	Labtech	1		1	
44	Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)						
45	Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation						
46	Submit/receive material for consultation (where applicable)						
47	Other Activity (please specify)						
48	**End: When specimen, chemical waste and record handling is complete**						
49	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
50	gloves, sterile	SB024	pair	2		2	
51	gown, staff, impervious	SB027	item	1			
52	scalpel, safety, surgical, with blade (#10-20)	SF047	item	1		1	
53	petri dish	SL301	item	1		1	
54	weighing dishes, pour boats	SL245	item	1		1	
55	*forceps, sterile disposable		item	1		1	
56	paper, weighing (glassine)	SL162	item	1		1	
57	plastic storage container, 11oz.		item	1		1	
58	bleach	SL020	ml	50		50	
59							
60	*Trade Winds, Inc. DF8088S						
61	Sterile Disposable Forceps, Polystyrene, blunt tip, $64.16/100						
62	64.16/100						
63							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Peripheral Electrical Bioimpedance

In October 2008, the CPT Editorial Panel revised code 93701 *Bioimpedance derived physiologic cardiovascular analysis* to fully describe all types of bioimpedance procedures presently in use. In 2001, the RUC recommended 0.00 physician work RVUs for 93701, as the physician work of reviewing this computer generated report is included as part of an associated E/M service. The RUC agreed the change was editorial. **The RUC reaffirmed their previous recommendation and recommends 0.00 work RVUs for 93701.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
93701	Bioimpedance – derived physiologic cardiovascular analysis, ~~thoracic, electrical~~	XXX	0.00 (PE Only)

414

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Infant Pulmonary Function Testing

In February 2009, the CPT Editorial Panel created three new CPT codes to describe the infant standard pulmonary function testing (PFT) that replicates adult PFTs with sedated infants or young children.

The specialty societies performed a survey of 40 physicians performing infant PFT in the U.S. The specialty acknowledged its low response rate of 26 may have contributed to the improper rank order of survey median physician work 94012 and 94013. The RUC reviewed these three new services, which are only performed in the facility setting, in relation to survey results and specialty recommended physician time and work effort in relation to other services to develop the recommendations.

415

94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
The RUC reviewed the specialty survey and specialty recommendations for new code 94011 and understood that the reduced pre-service time of 30 minutes (evaluation time only) from the standard package for a difficult sedated patient/straightforward procedure (33 minute evaluation time/1 minutes positioning time/5 minutes scrub, dress, wait time), appeared justified since the pediatric pulmonologists performing this test typically differs from the treating physicians (either pediatric pulmonologist or other physicians) with whom the family has a relationship established. Parents usually are shown the equipment (a clear body box that the infant is placed in, an airtight face-mask to be secured to the infant, and a pneumatic vest) as part of the informed consent process.

In support of the surveyed intra-service time (30 min), the RUC understood that infant PFTs include moderate sedation, as the physician actively performs the test. The technician calibrates the equipment, and assists in any resuscitation efforts. After the service, the physician speaks with the parents and the referring physician, and interprets the data in these difficult infants with cystic fibrosis. The RUC concurred that the correct physician time components for 94011 are 30 minutes pre-service, 30 minutes intra-service, and 20 minutes immediate post totaling 80 minutes.

The specialty recommended the survey median work RVU of 2.00 and the survey median physician time. In relation to this service, the RUC also reviewed the physician work of CPT code 99480 *Subsequent intensive care, per day, E/M of recovering infant 2501-*

5000g (Work RVU = 2.40), 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (Work RVU = 1.99 RVU), and 93312 *Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report* (Work RVU = 2.20), and agreed with the recommended value for 940X1 of 2.00. **The RUC recommends the survey median relative work value of 2.00 for CPT code 94011.**

94012 Measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age

The specialty recommended the survey median time, but argued that the survey median was too low. The RUC reviewed the specialty survey and specialty recommendations for new code 94012 and understood that the reduced pre-service time of 30 minutes (evaluation time only) from the standard package for a difficult sedated patient/straightforward procedure (33 minute evaluation time/1 minutes positioning time/5 minutes scrub, dress, wait time), appeared justified since the pediatric pulmonologists performing this test typically differs from the treating physicians (either pediatric pulmonologist or other physicians) with whom the family has a relationship established. Parents usually are shown the equipment (a clear body box that the infant is placed in, an airtight face-mask to be secured to the infant, and a pneumatic vest) as part of the informed consent process.

In support of the surveyed intra-service time (60 min), the RUC understood that infant PFTs include moderate sedation, and the physician actively performs the test, however in addition, the child is administered a bronchodilator after the first set of measurements, 10 minutes waiting time is necessary to permit the effect of albuterol (J code separately reported), 25 minutes additional time for making measurements. The RUC concurred that the survey respondents misunderstood this service in relation to 94011 and 94012, which provided for a disproportionately low value amongst this family of services.

The RUC developed a building block methodology to establish an appropriate work RVU. The RUC used 94011 as the base code that contains 30/30/20=80 total minutes of time and a RUC recommended value of 2.00. The survey indicated 94012 had 30 additional minutes of intra-service time above 94011. RUC took the intra-service work per unit of time (IWPUT) of 94011 (0.044) and multiplied it by the additional 20 minutes of active intra-service time for 94012, yielding 0.88 RVUs (20 x 0.044), then added the additional 10 min waiting intra-service time (10 x 0.0224 = 0.22 RVU), for a total of 1.10 RVUs (0.88+0.22 = 1.10). When added to the 2.00 RVUs from base code, 94011, this yields 3.10 work RVUs.

In relation to this service, the RUC also reviewed the physician work of CPT code 99480 *Subsequent intensive care, per day, E/M of recovering infant 2501-5000g* (Work RVU = 2.40), 96111 *Developmental testing; extended (includes assessment of motor, language,*

social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report (Work RVU = 2.60 RVU), and 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU = 3.00). and agreed with the recommended value for 94012 of 3.10 work RVUs. **The RUC recommends a relative work value of 3.10 for CPT code 94012.**

94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [VVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age

The specialty recommended that the survey results for this code were flawed, as the respondents did not understand that the service was essentially an add-on service. The RUC reviewed the specialty's survey results and understood that the work of 94013 occurs after spirometry measures are obtained with 94011 or 94012, the lungs are inflated passively, with another series of tests performed. The RUC agreed that the survey respondents did not understand the code being surveyed, and responded as if they were repeating the 94011. Therefore, the RUC removed all the pre-service time, reduced the intra-service time from the survey median of 42.5 minutes by 30 minutes to account for duplicative work performed in 94011, which left 12.5 minutes of intra-service time for 94013. The RUC also subtracted duplicative post-service time, resulting in 5 minutes of post-service time for interpretation of the data and relaying the results to the family.

417

The RUC used a building block methodology using 94002, *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99) as a building block base code to arrive at the value for 94013. The RUC used an IWPUT of 0.044 RVU per minute for the 12.5 minutes of intra-service work yielding 0.55 work RVUs. The 5 minutes post-service time at 0.0224 RVU per minute yields another 0.11 work RVUs to total a recommended 0.66 work RVUs for 94013. This code may be used twice if performed after both the initial testing and the post-bronchodilator study. The typical scenario is for 94013 to be used as an add-on code to 94011 or 94012, but could also be used as a stand alone code.

In relation to this service, the RUC also reviewed the physician work of CPT code 94620, *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)* (work RVU = 0.64, intra-service time = 15 minutes) and agreed that the services are similar, though 94013 requires greater intensity particularly because of the nature of the young patients. The RUC also reviewed 94070, *Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen[s], cold air, methacholine)* (work RVU = 0.60, intra-service time = 15 minutes, Harvard time), 92615, *Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only* (work RVU = 0.63, intra-time = 10 minutes), 93279, *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with*

physician analysis, review and report; single lead pacemaker system (work RVU = 0.65, intra-time = 10 minutes) and 95937, *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method* (work RVU = 0.65, intra-time = 12 minutes) and agreed with the recommended value for 940X3 of 0.66. **The RUC recommends a relative work value of 0.66 for CPT code 94013.**

New Technology: The RUC recommends that these services be placed on the RUC's New Technology list to be re-reviewed after 3 years of claims data are available.

Practice Expense: The RUC recommends no direct practice expense inputs for this set of codes as they are always performed in the facility setting.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
●⊙94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	XXX	2.00
●⊙94012	Measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age	XXX	3.10
●⊙94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [VVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	XXX	0.66

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94011 Tracking Number KK1 Specialty Society Recommended RVU: **2.00**

Global Period: XXX RUC Recommended RVU: **2.00**

CPT Descriptor: Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 5-month-old girl with cystic fibrosis has a chronic cough. An infant pulmonary function test is ordered to determine if there are abnormalities in forced expiratory flows.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Percent of survey respondents who stated they perform the procedure; In the hospital 96% , In the ASC 96%, In the office 19%

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

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

's moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

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

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

Description of Pre-Service Work: * The pre-service work is different from the work of an Evaluation and Management Service where the determination is made that spirometry be performed, and is not provided on the same day as Infant PFT. Often a different physician performs the test than the provider ordering it. This procedure is performed in a specialized room. The physician reviews the patient record. The procedure is explained with any potential complications to the parents. Informed consent is obtained including showing the parent the equipment and explaining the procedure. Instructions provided to RN/RT staff.The physician is present for its duration.

Description of Intra-Service Work: *The infant is sedated following the sedation proctocol and completes the paperwork with a review of the medication list, the vital signs and that the patient is npo. If the child awakens during the procedure, repeat sedation is administered.
* The mask is tightly sealed over the infants nose and mouth.
*The infant is placed inside an airtight, transparent box.
*A series of measurements are made before, during and after mechanically squeezing of the chest using a pneumatic vest. Repeated cycles are obtained to insure valididity.
requently the box must be opened and the infant repositioned in order to ensure a tight seal of the mask over the fant's face.

Description of Post-Service Work: * The physician evaluates the data to ensure accuracy, including review of the mid-maximal flow rates, examination of the flow-time curves, and comparision to available previous studies for significant

interval change according to the ATS/ERS Consensus Statement. The physician documents the results in the medical record. The patient is observed for any side effects from the sedation and then discharged into the care of the family.
* The physician discusses the results with the patient/family, and communicates the results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	Drs. Burt Lesnick, Scott Manaker (ACCP), Alan Plummer (ATS), and Steve Krug (AAP)		
Specialty(s):	ACCP, ATS, AAP		
CPT Code:	94011		
Sample Size:	40	**Resp N:** 26	**Response:** 65.0 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	**10.00**	25.00	65.00
Survey RVW:	0.25	1.00	**2.00**	3.21	6.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	20.00	**30.00**	82.50	150.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	94011	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**30.00**		

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

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
94010	XXX	0.17	**RUC Time**

CPT Descriptor Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,242,167

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	3.52	**RUC Time**	290,311

CPT Descriptor 2 Polysomnography, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU	Time Source
99254	XXX	3.29	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 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: 8 **% of respondents:** 30.7 %

TIME ESTIMATES (Median)	CPT Code: 94011	Key Reference CPT Code: 94010	Source of Time RUC Time
Median Pre-Service Time	30.00	0.00	
Median Intra-Service Time	30.00	5.00	
Median Immediate Post-service Time	20.00	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	**80.00**	**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	3.25	1.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.87	2.75
Urgency of medical decision making	3.00	2.37

Technical Skill/Physical Effort (Mean)

Technical skill required	3.25	2.75
Physical effort required	3.37	2.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.87	2.37
Outcome depends on the skill and judgment of physician	3.87	2.87
Estimated risk of malpractice suit with poor outcome	3.00	2.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.37	2.37
Intra-Service intensity/complexity	3.75	3.12
Post-Service intensity/complexity	3.00	2.87

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dditional 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.*

ACCP and ATS worked with AAP and derived a consensus recommendation through our respective committees.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) NOT REPORTED

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

Specialty Pulmonary Medicine How often? Rarely

Specialty Pediatrics How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 720
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Pulmonary Medicine Frequency 720 Percentage 100.00 %

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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? 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. 99480

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:94012 Tracking Number KK2 Specialty Society Recommended RVU: **3.10**

Global Period: XXX RUC Recommended RVU: **3.10**

CPT Descriptor: Measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-month-old boy has a chronic cough. An infant pulmonary function test is ordered to determine if there are abnormalities in forced expiratory flows and if they are reversible by a bronchodilator.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 96% , In the ASC 96%, In the office 19%

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

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

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

Description of Pre-Service Work: * The pre-service work is different from the work of an Evaluation and Management Service where the determination is made that spirometry be performed, and is not provided on the same day as Infant PFT. Often a different physician performs the test than the provider ordering it. This procedure is performed in a specialized room. The physician reviews the patient record. The procedure is explained with any potential complications to the parents. Informed consent is obtained including showing the parent the equipment and explaining the procedure. Instructions provided to RN/RT staff.The physician is present for its duration.

Description of Intra-Service Work: * The infant is sedated following the sedation proctocol and completes the paperwork with a review of the medication list, the vital signs and that the patient is npo.
*The mask is tightly sealed over the infants nose and mouth.
*The infant is placed inside an airtight, transparent box.
*A series of measurements are made before, during and after mechanically squeezing of the chest using a pneumatic vest. Repeated cycles are obtained to insure valididity.
*Frequently the box must be opened and the infant repositioned in order to ensure a tight seal of the mask over th infant's face.
*A bronchodilator is then administered after which the physician must wait for its effects. The above procedure is then repeated.
*If the child awakens, repeat sedation is administered.

Description of Post-Service Work: * The physician evaluates the data to ensure accuracy, including review of the mid-maximal flow rates, examination of the flow-time curves, and comparision to available previous studies for significant interval change according to the ATS/ERS Consensus Statement. The physician documents the results in the medical record. The patient is observed for any side effects from the sedation or bronchodilator and then discharged into the care of the family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	Drs. Burt Lesnick, Scott Manaker (ACCP), Alan Plummer (ATS), and Steve Krug (AAP)		
Specialty(s):	ACCP, ATS and AAP		
CPT Code:	94012		
Sample Size:	40	**Resp N:** 26	**Response:** 65.0 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	**10.00**	30.00	60.00
Survey RVW:	0.31	1.41	**2.37**	4.00	6.50
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	40.00	**60.00**	90.00	200.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	94012	**Recommended Physician Work RVU: 3.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
94060	XXX	0.31	**RUC Time**

CPT Descriptor Bronchodilator responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,242,167

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	3.52	**RUC Time**	290,311

CPT Descriptor 2 Polysomnography, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU	Time Source
99255	XXX	4.00	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. 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.

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 34.6 %

TIME ESTIMATES (Median)	CPT Code: 94012	Key Reference CPT Code: 94060	Source of Time RUC Time
Median Pre-Service Time	30.00	5.00	
Median Intra-Service Time	60.00	10.00	
Median Immediate Post-service Time	25.00	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	**115.00**	**20.00**
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	1.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	2.66
Urgency of medical decision making	3.00	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.22	2.66
Physical effort required	3.33	2.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.11	2.44
Outcome depends on the skill and judgment of physician	3.88	3.11
Estimated risk of malpractice suit with poor outcome	2.88	2.22

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

Time Segments (Mean)

Pre-Service intensity/complexity	3.33	2.33
Intra-Service intensity/complexity	3.66	3.00
Post-Service intensity/complexity	3.00	2.55

Additional Rationale

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

ACCP and ATS worked with AAP and derived a consensus recommendation through our respective committees.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) NOT REPORTED

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

Specialty Pulmonary Medicine How often? Rarely

Specialty Pediatrics How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 720
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Pulmonary Medicine Frequency 720 Percentage 100.00 %

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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? 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. 99480

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:94013 Tracking Number KK3 Specialty Society Recommended RVU: **0.66**

Global Period: XXX RUC Recommended RVU: **0.66**

CPT Descriptor: Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-month-old girl has survived perinatal lung surgery to remove a congenital cystic adenomatous malformation. Lung volumes are being assessed to determine compensatory growth.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Percent of survey respondents who stated they perform the procedure; In the hospital 96% , In the ASC 96%, In the office 19%

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

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

Description of Pre-Service Work: * The pre-service work is different from the work of an Evaluation and Management Service where the determination is made that spirometry be performed, and is not provided on the same day as Infant PFT. Often a different physician performs the test than the provider ordering it. This procedure is performed in a specialized room. The physician reviews the patient record. The procedure is explained with any potential complications to the parents. Informed consent is obtained including showing the parent the equipment and explaining the procedure. Instructions provided to RN/RT staff. The physician is present for its duration..

Description of Intra-Service Work: *The infant is sedated following the sedation proctocol and completes the paperwork with a review of the medication list, the vital signs and that the patient is npo. If the child awakens during the procedure, repeat sedation is administered.
*The mask is tightly sealed over the infants nose and mouth.
*The infant is placed inside an airtight, transparent box.
*A series of measurements are made before, during and after mechanically squeezing of the chest using a pneumatic vest. Repeated cycles are obtained to insure valididity.
Frequently the box must be opened and the infant repositioned in order to ensure a tight seal of the mask over the infant's face.
*The infant's lungs are then passively inflated to total lung capacity. The above procedure is then repeated with multiple measurements after passive inflation.

Description of Post-Service Work: * The physician evaluates the data to ensure accuracy, including review of the mid-maximal flow rates, examination of the flow-time curves, and comparision to available previous studies for significant interval change according to the ATS/ERS Consensus Statement. The physician documents the results in the medical record. The patient is observed for any side effects from the sedation or bronchodilator and then discharged into the care of the family.

* The physician discusses the results with the patient/family, and communicates the results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Drs. Burt Lesnick, Scott Manaker (ACCP), Alan Plummer (ATS), and Steve Krug (AAP)				
Specialty(s):	ACCP, ATS and AAP				
CPT Code:	94013				
Sample Size:	40	**Resp N:**	26	**Response:** 65.0 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	**11.00**	35.00	65.00
Survey RVW:	0.31	1.00	**2.20**	3.88	6.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	30.00	**42.50**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	94013	**Recommended Physician Work RVU: 0.66**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**33.00**	**-33.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**12.50**		

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

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
99255	XXX	4.00	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. 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	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,242,167

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	3.52	**RUC Time**	290,311

CPT Descriptor 2 Polysomnography, sleep staging with 4 or more additional parameters of sleep, attended by technologist

Other Reference CPT Code	Global	Work RVU	Time Source
99254	XXX	3.29	**RUC Time**

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 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:** 19.2 %

TIME ESTIMATES (Median)	CPT Code: 94013	Key Reference CPT Code: 99255	Source of Time RUC Time
Median Pre-Service Time	0.00	20.00	
Median Intra-Service Time	12.50	60.00	
Median Immediate Post-service Time	5.00	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	**17.50**	**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	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	4.40
Urgency of medical decision making	3.40	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.60
Physical effort required	4.40	4.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	3.60
Outcome depends on the skill and judgment of physician	4.80	4.20
Estimated risk of malpractice suit with poor outcome	4.20	3.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.40	3.00
Intra-Service intensity/complexity	3.60	3.20
Post-Service intensity/complexity	3.60	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.*

SERVICES REPORTED WITH MULTIPLE 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 unliste code is reviewed) NOT REPORTED

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

Specialty Pulmonary Medicine How often? Rarely

Specialty Pediatrics How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 720
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Pulmonary Medicine Frequency 720 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. Pleas 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? No

If no, please select another crosswalk and provide a brief rationale. 94070

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Nerve Conduction Tests

The CPT Editorial Panel created one new Category I CPT code to describe a new nerve conduction test performed with newer technologies that differ from traditional technologies. The Editorial Panel created, 95905, *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report* at its October 2008 Meeting. The Editorial Panel specified that this codes may be reported only once per limb studied.

The specialty societies presented survey data from 75 physicians; however, the median service performance rate of all surveyees was zero. Following RUC policy, the specialties provided additional data from their original survey, including the compilation of responses from physicians with a service performance rate of at least one and the compilation of responses from physicians with a service performance rate of zero, which the RUC compared with the aggregate data in the Summary of Recommendation form. The specialties also provided a complete description of the work that is included in the procedure to support the contention that there is physician work involved since it was noted that 21 of the survey respondents compared the new code to a reference code with no physician work. Based on this description and the overall survey results, the RUC agreed that although the median survey work RVUs and some of the surveyed physician times are inflated, a small amount of physician work is appropriate. The RUC reviewed the times recommended by the specialties and noted that there is no pre-service or post-service physician time and that the physician work is only performed during the intra-service period. Specifically, the RUC decided that the physician work described by the specialties within the pre-service time is included within the evaluation and management service that is typically reported on the same day and that the physician work described by the specialties within the post-service time is inappropriate and is included within the five minutes of intra-service time. The RUC compared 95905 to 76977, *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05, intra-service = 5 minutes), which is identical in physician time and work. The RUC agreed that 76977 serves as a direct comparison code and the appropriate work RVU for 95905 is 0.05, based on this magnitude estimation. The Committee also noted that 0.05 is the survey 25th percentile work RVU. The RUC also commented that this service is Modifier 51 exempt and assumed it may often be reported more than once, supporting pre- and post-service times of 0 minutes. **Therefore, the RUC recommends a work RVU of 0.05, no pre- or post-service time and five minutes of intra-service time for 95905.**

443

Practice Expense
The RUC reviewed the practice expense inputs and revised the clinical staff time to reflect that multiple units of services are typically reported.

PLI
The RUC recommends a PLI crosswalk to the key reference service, 76977-26 (the professional component only).

New Technology
The RUC recommends that 95905 is placed on the New Technology list.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
The following applies to nerve conduction tests (95900-95904): Codes 95900-95904 describe nerve conduction tests when performed with individually placed stimulating, recording, and ground electrodes. The stimulating, recording, and ground electrode placement and the test design must be individualized to the patient's unique anatomy. Nerves tested must be limited to the specific nerves and conduction studies needed for the particular clinical question being investigated. The stimulating electrode must be placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches. In most motor nerve conduction studies, and in some sensory and mixed nerve conduction studies, both proximal and distal stimulation will be used. Motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested. Waveforms must be reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) must be adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves. Reports must be prepared on site by the examiner, and consist of the work product of the interpretation of numerous test results, using well-established techniques to assess the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of each nerve tested. This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values, summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation. Code 95905 describes nerve conduction tests when performed with preconfigured electrodes customized to a specific anatomic site.				

444

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95900		Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	XXX	0.42 (No Change)
●95905	M1	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report (Report 95905 only once per limb studied) (Do not report 95905 in conjunction with 95900-95904, 95934-95936)	XXX	0.05

445

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95905 Tracking Number M1 Specialty Society Recommended RVU: **0.15**

Global Period: XXX RUC Recommended RVU: **0.05**

CPT Descriptor: Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report
(Report 95905 only once per limb studied)
(Do not report 95905 in conjunction with 95900-95904, 95934-95936)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old female data entry clerk reported that, although she had had no injuries and during the day she was okay, she had been awakened in the middle of each night for the past two weeks with a numb, aching, burning feeling in her right hand that was relieved by holding her hand down and shaking it, rubbing it and running cold water over it. Physical examination reveals weakness of right thumb abduction, wasting of the right thenar eminence, numbness of the palmar aspects of the right thumb, index finger and middle finger, and a Tinel's sign over the right median nerve at the carpal tunnel. (History and exam reported separately as E/M). Nerve conduction testing using preconfigured arrays for the right arm is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

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

Description of Pre-Service Work:

Description of Intra-Service Work: The physician reviews a summary of electrodiagnostic data from each nerve tested and assesses it in the context of comparison to normal values and the patient's history and physical examination.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009
Presenter(s):	Gregory Barkley, MD (AAN); Andrea Boon, MD (AANEM); Neil Busis, MD (AAN); Lee Mills, MD (AAFP); John A. Seibel, MD, MACE (AACE); Benn Smith, MD (AANEM)
Specialty(s):	American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Association of Clinical Endocrinologists (AACE), American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), American Clinical Neurophysiology Society (ACNS)
CPT Code:	95905
Sample Size:	380 **Resp N:** 75 **Response:** 19.7 %
Sample Type:	Panel

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	4.50	933.00
Survey RVW:	0.00	0.05	**0.15**	0.40	45.50
Pre-Service Evaluation Time:			**3.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	0.50	**5.00**	10.00	45.00

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	95905	**Recommended Physician Work RVU: 0.05**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

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

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
92586	XXX	0.00	

CPT Descriptor AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM; LIMITED

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95165	XXX	0.06	**RUC Time**	5,839,746

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	20,245,535

CPT Descriptor 2 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Other Reference CPT Code	Global	Work RVU	Time Source
93000	XXX	0.17	**RUC Time**

CPT Descriptor Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 28.0 **%**

TIME ESTIMATES (Median)	CPT Code: 95905	Key Reference CPT Code: 92586	Source of Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	5.00	0.00	
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**	**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	1.81	2.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.48	1.95
Urgency of medical decision making	1.38	1.76

Technical Skill/Physical Effort (Mean)

Technical skill required	1.33	2.33
Physical effort required	1.19	1.76

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.24	1.71
Outcome depends on the skill and judgment of physician	1.67	2.29
Estimated risk of malpractice suit with poor outcome	2.10	1.86

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

Time Segments (Mean)

Pre-Service intensity/complexity	1.24	1.48
Intra-Service intensity/complexity	1.19	1.90
Post-Service intensity/complexity	1.43	2.10

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 survey received 75 responses from among the 5 surveying societies.

Since the majority of respondents have not performed this service, the group also examined survey data based on only those who had performed the service in the last year. Based on that data, the median RVW was 0.17 and the times were 3 minutes pre-service, 5 minutes intra-service, and 5 minutes post-service. The results were very similar to the complete survey 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) This procedure is typically reported on the same day as an E/M service.

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

CPT Code		Global Period	RVW	Pre-time	Intra-time	Post-time	Total Time
9590X1	XXX	?	3	5	4	12	
99213	XXX	0.92	3	15	5	23	

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95900, 95903, 95904

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 Family Physicians — How often? Sometimes

Specialty Endocrinology — How often? Sometimes

Specialty Neurology — How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 4000000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We multiplied our estimates for Medicare times 4 to estimate national utilization.

Specialty Family Physicians — Frequency 2500000 — Percentage 62.50 %

Specialty Endocrinology — Frequency 1495000 — Percentage 37.37 %

Specialty Neurology — Frequency 5000 — Percentage 0.12 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We examined Medicare utilization data of 95900, 95903, and 95904 by family practice and internal medicine for 2006 and estimated most of the codes would have been reported for automated nerve testing services.

Specialty Family Physicians Frequency 625000 Percentage 62.50 %

Specialty Endocrinology Frequency 373750 Percentage 37.37 %

Specialty Neurology Frequency 1250 Percentage 0.12 %

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. 76997

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

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

CPT Long Descriptor:

Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report
(Report 95905 only once per limb studied)
(Do not report 95905 in conjunction with 95900-95904, 95934-95936)

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

The RUC advisors from the five specialty societies that surveyed the physician work involved with this code formed a joint RVS panel to formulate the recommendations regarding direct practice expense inputs. The joint RVS panel met twice by conference call and also exchanged information by e-mail. The panel members relied on their own experience and knowledge of the service to formulate the recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MA:

Intra-Service Clinical Labor Activities:

RN/LPN/MA: Reviews test orders and relevant clinical information. Files pre-authorization paperwork if necessary. Ensures adequate supply of electrodes for the ordered testing. Escorts patient from registration area to exam site and instructs patient on appropriate limb exposure, gowning if necessary. Explains testing procedure, purpose, and side effects. Positions patient for study, then cleans and preps indicated limb. Stimulating and recording surface electrode components of the nerve specific pre-configured electrode arrays are placed. Testing involves automated stimulation of nerves and recording of the waveforms of the resulting compound muscle or sensory nerve action potentials. The waveforms are transmitted electronically for computer generated analysis with respect to latency, amplitude, and configuration. Provides discharge instructions. Gathers data report and clinical information for interpretation by physician. Tracks and reorders electrode supplies as needed. Performs internal Q/A activity.

Post-Service Clinical Labor Activities:

RN/LPN/MA:

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**95905**	
2	**Meeting Date: January 29 - February 1, 2009**	**CMS**	**Staff**	**Motor and/or sensory nerve conduction, using preconfigured electrode**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**	**XXX**			
5	**TOTAL CLINICAL LABOR TIME**			**8.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**8.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms			**0**	**0**
12	Coordinate pre-surgery services				
13	Schedule space and equipment in facility				
14	Provide pre-service education/obtain consent				
15	Follow-up phone calls & prescriptions				
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review charts			**0**	
21	Greet patient and provide gowning				
22	Obtain vital signs				
23	Provide pre-service education/obtain consent			**1**	
24	Prepare room, equipment, supplies			**2**	
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV				
27	Sedate/apply anesthesia				
28	**Intra-service**				
29	Perform the test			**4**	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff				
33	Clean Scope				
34	Clean Surgical Instrument Package				
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Uploading and restore equipment to docking station			**1**	
38	Discharge day management				
39	Other Clinical Activity (please specify)				
40	**End: Patient leaves office**				
41	**POST-SERVICE Period**				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions				
44	*Office visits:* ***None***				
51	Other				
52	*Total Office Visit Time*			**0**	**0**
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**		Unit		
56	preconfigured nerve electrode array	NEW	array	**1**	**0**
57	paper, exam table	SB036	foot	**0**	
58	swab-pad, alcohol	SJ053	item	**2**	
59	**Equipment**				
60	table, exam	EF023		**8**	**0**
61	automated nerve conduction testing device (e.g., NC-stat® System)	NEW		**8**	**0**

Supplemental Data for Tab 18

	Aggregate/SOR Data					User Data					Non-user Data				
Total Number of Respondents	75					26					49				
Percentage of Survey Respondents who found Vignette to be Typical	73%					81%					71%				
	Low	25th	Med	75th	High	Low	25th	Med	75th	High	Low	25th	Med	75th	High
Service Performance Rate	0	0	0	4.5	933	1	2.5	15	50	933	0	0	0	0	0
Survey RVW	0	0.05	0.15	0.40	45.5	0	0.088	0.17	0.663	45.5*	0	0.01	0.125	0.203	2.75
Pre-Service Evaluation Time			3					3					2		
Intra-Service Time			5					5					5		
Immediate Post Service Time			4					5					2		
Key Reference Service	92586: RVU 0.00					92586: RVU 0.00					92586: RVU 0.00		93000: RVU 0.17		
Key Reference Service Descriptor	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited					Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited					Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited		Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report		
Number of Respondents who chose Key Reference Code	21					7					14		14		
Percent of Respondents who chose Key Reference Code	28%					27%					29%		29%		
INTENSITY/COMPLEXITY MEASURES (Mean)	95905		92586			95905		92586			95905	92586	95905	93000	
Mental Effort & Judgment															
The number of possible diagnosis and/or the number of management options that must be considered	1.81		2.19			2.14		2			1.71	2.29	1.86	2.71	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.48		1.95			1.43		1.71			1.5	2	1.71	2.29	
Urgency of medical decision making	1.38		1.76			1.29		1.43			1.43	1.86	1.57	3.07	
Technical Skill/Physical Effort															
Technical Skill Required	1.33		2.33			1		2.57			1.5	2.21	1.71	2.34	
Physical Effort Required	1.19		1.76			1		1.57			1.29	1.79	1.64	1.57	

*With the anomalous 45.5 RVW removed, the RVW values are:

Low	25th	Med	75th	High
0	0.075	0.17	0.55	2

Supplemental Data for Tab 18

INTENSITY/COMPLEXITY MEASURES (Mean)	95905	92586	95905	92586	95905	92586	95905	93000
Psychological Stress								
The risk of significant complications, morbidity, and/or mortality	1.24	1.71	1.29	1.57	1.29	1.71	1.64	2
Outcome depends on the skill and judgment of physician	1.67	2.29	1.57	2.14	1.5	2.14	2.29	2.93
Estimated risk of malpractice suit with poor outcome	2.10	1.86	1.71	1.57	2.21	1.93	2.07	3.14
Time Segments								
Pre-service intensity/complexity	1.24	1.48	1.43	1.43	1.14	1.5	1.71	1.71
Intra-service intensity/complexity	1.19	1.90	1	1.71	1.29	2	1.71	1.86
Post-service intensity/complexity	1.43	2.10	1.29	2	1.43	2.07	1.57	1.86

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Endoscopic Photodynamic Therapy Application

In February 2009, the CPT Editorial Panel edited two codes that initially described photodynamic therapy by endoscopic application of light (photodynamic therapy) in two specific anatomic regions, the lungs and esophagus. The procedure described endoscopic light application to a single region (esophagus) of the gastrointestinal tract. However, other areas of the gastrointestinal tract (e.g. oral cavity, biliary tract) are also frequently treated using endoscopic application of light. The CPT Editorial Panel deleted the word "esophagus" and replaced it with "gastrointestinal tract" to include areas of the gastrointestinal tract beyond the esophagus. Since the current RUC survey results for endoscopic photodynamic therapy were nine years old, interim, and were never validated by the RUC, the specialties performed a full RUC survey.

465

96570 ***Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)***
The RUC reviewed the specialty societies' survey data and agreed with the specialty that the survey results overestimated the physician time and work performed. The RUC and specialties agreed that the 25th percentile survey work value survey results was too high at 1.75 RVUs, however the RUC determined that the survey 25th percentile intra-service time of 30 minutes was appropriate for this service. After reviewing the survey results, the specialties could not provide compelling evidence to warrant an increase to the current work value of 1.10 RVUs.

The RUC compared the physician work required to perform 96570 to the following other add-on services: 31620 *Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])*(Work RVU = 1.40), 31632 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* (Work RVU = 1.03), 31637 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)* (Work RVU = 1.58), 13102 *Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)* (Work RVU = 1.24). Since this service is an add on to other endoscopy or bronchoscopy procedures of the lung and gastrointestinal tract, the specialty recommended, and the RUC agreed that the service has no pre- or post-service physician time.

After reviewing these services and the survey time, the RUC determined that the current work for this service is appropriate. **The RUC recommends a relative work value of 1.10 for CPT code 96570 with physician time of 30 minutes (intra-service), with zero minutes of pre- or post service time.**

96571 ***Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)***

The specialty survey results for 96571 consisted of 17 respondents which the specialty societies believed provided an overvaluation of physician work and time. All of the survey respondents included pre and post physician time in their responses for this add-on code. The specialties could not identify pre and post service work of the surveyed code to explain the survey times. In addition, the specialty could not explain a median response of 40 minutes intra-service time for a surveyed procedure which is defined as taking up to 15 minutes. The specialty society and the RUC concluded that the survey respondents either included pre and/or post time associated with the broncoscopy / endoscopy procedure that is performed with the surveyed code, or that the respondents did not understand the RUC survey process. The specialty society and the RUC concurred that the survey data was flawed and unusable. The specialties agreed to use a consensus panel approach which resulted in a physician work RVU recommendation of half the value of 96570, based on half the time (30 verses 15 minutes) as defined in the CPT descriptor. The RUC agreed with the specialty societies approach to value this service and reviewed the work of 96571 in relation to 97814 *Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)* (Work RVU = 0.55, ZZZ global period, 15 minutes intra-service time). The RUC concurred that the physician work intensity and complexity of 96571 is identical to 96570 and requires half the time (15 intra-service minutes). **The RUC recommends a relative work value of 0.55 for CPT code 96571 with physician time of 15 minutes (intra-service), with zero minutes pre or post service time.**

Practice Expense: The RUC recommends no direct practice expense inputs for codes 96570 and 96571 in either the non-facility or facility settings.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲+96570	MM1	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and ~~esophagus~~ gastrointestinal tract)	ZZZ	1.10 (No Change)
▲+96571	MM2	each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and ~~esophagus~~ gastrointestinal tract) *(96570, 96571 are to be used in addition to bronchoscopy, endoscopy codes)* *(Use 96570, 96571 in conjunction with 31641, 43228 as appropriate)*	ZZZ	0.55 (No Change)

467

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96570 Tracking Number MM1 Specialty Society Recommended RVU: **1.10**

Global Period: ZZZ RUC Recommended RVU: **1.10**

CPT Descriptor: Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old male with a history of smoking and alcohol use complains of extreme difficulty with swallowing. Endoscopic examination is performed and reveals esophageal cancer. A computed tomography scan shows adjacent lymph node and celiac involvement. A determination is made that the patient is not a candidate for surgical resection. The patient receives radiation therapy and chemotherapy.

Subsequently, the patient develops recurrent complaints of dysphagia. Reassessment reveals that the tumor has progressed and is surgically non-resectable. Therapy of the patient's dysphagia using photodynamic therapy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 51%

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 88%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 75%

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work:
- Diffuser tip is inserted, the endoscopic laser light source is activated and applied to the tumor
- 2.5 minutes of endoscopic laser light using a 2.5 cm cylindrical diffusing fiberoptic endoscope are required for every 5 mm of tumor length
- During each application, the light source is periodically turned off so that the position of both the endoscope and the diffuser may be checked
- At the completion of the procedure, the light application is turned off and the endoscope with the diffuser tip is withdrawn

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009
Presenter(s):	Joel V. Brill, MD, AGAF, FASGE, FACG, CHCQM; Burt Lesnick, MD, FCCP; Scott Manaker, MD, PhD, FCCP; Nicholas Nickl, MD; Alan L. Plummer, MD, FCCP; Keith Naunheim, MD
Specialty(s):	American College of Chest Physicians (ACCP), American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), American Thoracic Society (ATS), and The Society of Thoracic Surgeons (STS)/American Association for Thoracic Surgery (AATS)
CPT Code:	96570

Sample Size:	114	**Resp N:**	27	**Response:** 23.6 %
Sample Type:	Convenience			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**5.00**	8.00	25.00
Survey RVW:	1.00	1.75	**1.95**	2.45	7.50
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	120.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	96570	**Recommended Physician Work RVU: 1.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**

Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31637	ZZZ	1.58	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	RUC Time	11,931

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
31620	ZZZ	1.40	RUC Time

CPT Descriptor Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 29.6 %

TIME ESTIMATES (Median)	CPT Code: 96570	Key Reference CPT Code: 31637	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**30.00**	**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	3.75	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.63
Urgency of medical decision making	3.75	3.88
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.88	4.13
Physical effort required	3.88	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.75	3.63
Outcome depends on the skill and judgment of physician	3.88	4.00
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	3.13
Intra-Service intensity/complexity	3.63	3.63
Post-Service intensity/complexity	3.13	3.13

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.*

The American College of Chest Physicians (ACCP), American Gastroenterological Association (AGA), American ociety for Gastrointestinal Endoscopy (ASGE), American Thoracic Society (ATS), and The Society of Thoracic urgeons (STS)/American Association for Thoracic Surgery (AATS) conducted a survey of code +96570, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract). The parenthetical for code 96570 was revised at the February 2009 CPT Editorial Panel meeting to include areas of the gastrointestinal tract beyond the esophagus. Although the societies considered the

revision accepted during the CPT Editorial Panel meeting to be editorial, as the previously accepted physician work values were considered interim, the RUC requested the societies to survey the code.

After reviewing the survey data, the societies recommend maintaining the current work value of 1.10 WRVUs. The societies recommend 30 minutes of physician intra-service time and no pre and post time. The recommended WRVU is less than the 25th percentile value from the survey.

Survey Process

The survey was electronically disseminated to 114 practicing gastroenterologists, pulmonologists, and thoracic surgeons. A total of 27 responses (23.6% response rate) were received.

Survey Data

The societies convened an expert panel to review the survey data for code +96570.

+96570 Survey Data

RVU	All	GI-Only	Pulm-Only	ThorSurg-Only	Other (ENT)
# of Responses	27	8	14	4	1
Low	1.00	1.32	1.00	1.35	
25th	1.75	1.79	1.71	1.65	
Median	**1.95**	**2.00**	**2.00**	**1.83**	**7.50**
75th	2.45	2.75	2.29	1.98	
High	7.50	3.80	6.00	2.20	

PHY TIME	All	GI-Only	Pulm-Only	ThorSurg-Only	Other (ENT)
Pre-Service Time					
Median	30	60	35	17.5	30
Intra Time					
Low	15	20	15	40	
25th	30	30	32.5	43.75	
Median	**45**	**47.5**	**52.5**	**47.5**	**30**
75th	60	60	60	52.5	
High	120	90	120	60	
Post Time					
Median	20	35	20	20	120

An expert panel comprised of representatives from the Pulmonary, Gastroenterology, and Thoracic Surgery societies was convened to review the survey data. The panel had significant concerns with the survey data. Although a ZZZ code typically has only intra-service physician time associated with it, all of the survey respondents included pre and post physician time in their responses. The panel could not identify pre and/or post service work of the surveyed code to explain the survey times. In addition, the panel could not explain a median response of 45 minutes intra-service time for a surveyed procedure which was defined as taking up to 30 minutes. The panel concluded that the survey respondents either included pre- and/or post- time associated with the bronchoscopy / endoscopy procedure that is performed with the surveyed code, or that the respondents did not understand the RUC survey process.

After considering numerous options, the panel was unable to accurately link time and RVUs from the survey data. The panel concluded that the survey data was flawed and unusable. ***A consensus was reached to dismiss the data and develop work and physician time recommendations based on a consensus panel approach.***

A Note on the Moderate Sedation Survey Question

Moderate sedation is NOT inherent to the PDT. Rather, it is inherent to the base procedure (esophagoscopy, bronchoscopy). The panel of experts concluded that a high number of survey respondents indicated that it was inherent to +96570 due to confusion on the part of survey respondents.

Work and Physician Time Recommendation Development – Consensus Panel Approach

Time Recommendation Development

Code +96570 is a ZZZ code that is always performed with either an endoscopy or bronchoscopy procedure. The endoscopy or bronchoscopy is performed in order for the physician to gain access for the photodynamic therapy. The code descriptor defines up to 30 minutes of treatment. The Panel agreed that there was no pre or post service work

unique to the photodynamic therapy (PDT) that was not associated with the separately billed endoscopy / bronchoscopy procedure.

Based on these factors the panel concluded that 30 minutes of intra-service physician time was an appropriate recommendation.

Work Recommendation Development

Comparison to Codes on Reference Service List

The panel reviewed work and time data for codes on the reference service list (RSL). The RSL represents services familiar to the survey respondents and, to an extent, reflects a spectrum of the ZZZ global services provided by the three specialties.

The Panel considered 3 codes in particular:

- 31620, Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])
- 31632, Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)
- 31637, Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)

Code 31620 was the most common code chosen from the reference list when data from all of the specialties, pulmonology-only, and gastroenterology-only survey responders was analyzed.

Code	Global	Data Source	WRVU	Pre Time	Intra Time	Post Time	IWPUT
31620	ZZZ	RUC	1.40	0	20	0	0.070
31632	ZZZ	RUC	1.03	0	18	0	0.057
31637	ZZZ	RUC	1.58	0	30	0	0.053

The Panel could not identify a compelling reason to change the current WRVU value of 1.10. With a WRVU of 1.10 and 30 minutes of intra-service time the code +96570 has an IWPUT of 0.037 which is significantly lower than the similar services on the reference service list and other commonly performed services provided by the three specialties.

The panel agreed that the current value of 1.10 fell appropriately within the range of these other services:

- +31637 – While both +96570 and +31637 are 30 minute procedures, the panel agreed that +96570 is a slightly less intense procedure and a lower WRVU value was appropriate
- +31632 – The panel concluded that the longer intra-service time for +96570 justified the slightly higher recommended value for the code
- +31620 – While code +31620 has less time and a higher WRVU than is being recommended for code +96570, the panel concluded that this was appropriate due to the greater intensity of code +31620.

Comparison to Other ZZZ Codes

The societies also looked at ZZZ codes outside of the families of codes performed by the specialties who surveyed this code and identified several codes with 30 minute of intra time which support the recommended value. Virtually all of the identified codes have RVWs well in excess of 1.10. We will cite just two for comparison purposes. Code 99355, Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged physician service) is assigned an RVW of 1.77 for 30 minutes of intra time only. Code 95975, 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); complex 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) is assigned an RVW of 1.70 for 30 minutes of intra time only.

On the MPC list, Code 13102 (Repair, complex, trunk; each additional 5 cm or less) a ZZZ Code with 25 minutes intra-service and total time has a WRVU of 1.24. Code 13133 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less) a ZZZ Code with 30 minutes intra-service and total time has a WRVU of 2.19.

In summary, we could not identify a compelling reason to change the current work RVW of 1.10 and consider the recommended RVW comparable to the values for other bronchoscopy codes with ZZZ global periods and to other ZZZ codes not typically performed by the surveyed specialties. In addition, the IWPUT of 0.037 is substantially less than the IWPUT assigned to high volume E/M codes including office visits for established patients.

In view of the above, the societies recommend 1.10 WRVUs and physician time of 30 minutes (intra-service), with zero minutes of pre- or post-service time, for code +96570.

SERVICES REPORTED WITH MULTIPLE 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. SCENARIO A - Reported with code 31641, Bronchoscopy (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)

3. CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
4. 31641	000	5.02	HARVARD	48	70	23

5.

6. SCENARIO B - Reported with code 43228, Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

7. CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
8. 43228	000	3.76	HARVARD	45	40	23

9.

10. SCENARIO C – Reported with code 43258, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

11. CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
12. 43258	000	4.54	RUC	21	46	20

13.

14. SCENARIO D – Reported with code 43272, Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

15. CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
16. 43272	000	7.38	RUC	25	60	20

17.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) +96570, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue vi activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)

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 Pulmonology How often? Rarely

Specialty Thoracic Surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1035
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 data received from the National Council for Prescription Drug Programs (NCPDP)

Specialty Thoracic Surgery Frequency 424 Percentage 40.96 %

Specialty Gastroenterology Frequency 353 Percentage 34.10 %

Specialty Pulmonology Frequency 103 Percentage 9.95 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 413
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2007 Medicare utilization data

Specialty Thoracic surgery Frequency 169 Percentage 40.92 %

Specialty Gastroenterology Frequency 141 Percentage 34.14 %

Specialty Pulmonology Frequency 41 Percentage 9.92 %

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. Current code 96570

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:96571 Tracking Number MM2 Specialty Society Recommended RVU: **0.55**

Global Period: ZZZ RUC Recommended RVU: **0.55**

CPT Descriptor: Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: In the same session additional therapy of the patient's dysphagia using photodynamic therapy is performed for the patient described below.

A 74-year-old male with a history of smoking and alcohol use complains of extreme difficulty with swallowing. Endoscopic examination is performed and reveals esophageal cancer. A computed tomography scan shows adjacent lymph node and celiac involvement. A determination is made that the patient is not a candidate for surgical resection. The patient receives radiation therapy and chemotherapy.

Subsequently, the patient develops recurrent complaints of dysphagia. Reassessment reveals that the tumor has progressed and is surgically non-resectable. Therapy of the patient's dysphagia using photodynamic therapy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 58%

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

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

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 76%

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Because of the size of the tumor, the treatment session lasts an additional 15 minutes beyond the initial 30 minutes assigned to Code 96570.

- 2.5 minutes of endoscopic laser light using a 2.5 cm cylindrical diffusing fiberoptic endoscope are required for every 5 mm of tumor length
- During each application, the light source is periodically turned off so that the position of both the endoscope and the diffuser may be checked
- At the completion of the procedure, the light application is turned off and the endoscope with the diffuser tip is withdrawn

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009
Presenter(s):	Joel V. Brill, MD, AGAF, FASGE, FACG, CHCQM; Burt Lesnick, MD, FCCP; Scott Manaker, MD, PhD, FCCP; Nicholas Nickl, MD; Alan L. Plummer, MD, FCCP; Keith Naunheim, MD
Specialty(s):	American College of Chest Physicians (ACCP), American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), American Thoracic Society (ATS), and The Society of Thoracic Surgeons (STS)/American Association for Thoracic Surgery (AATS)
CPT Code:	96571

Sample Size:	114	**Resp N:**	17	**Response:**	14.9 %
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.25	**5.00**	7.25	25.00
Survey RVW:	0.55	1.10	**1.58**	2.50	6.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	20.00	**40.00**	45.00	120.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	96571	**Recommended Physician Work RVU: 0.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**

Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31637	ZZZ	1.58	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
31632	ZZZ	1.03	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (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: 96571	Key Reference CPT Code: 31637	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	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	**15.00**	**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	3.41	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.29
Urgency of medical decision making	3.29	3.24
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.65	3.65
Physical effort required	3.47	3.41
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.65	3.59
Outcome depends on the skill and judgment of physician	3.76	3.71
Estimated risk of malpractice suit with poor outcome	3.65	3.53

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.18	2.88
Intra-Service intensity/complexity	3.35	3.29
Post-Service intensity/complexity	3.06	3.06

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.*

The American College of Chest Physicians (ACCP), American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), American Thoracic Society (ATS), and The Society of Thoracic Surgeons (STS)/American Association for Thoracic Surgery (AATS) conducted a survey of code +96571, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract). This parenthetical for code 96571

was revised at the February 2009 CPT Editorial Panel meeting to include areas of the gastrointestinal tract beyond the esophagus. Although the societies considered the revision accepted during the CPT Editorial Panel meeting to be editorial, as the previously accepted physician work values were considered interim, the RUC requested the societies to survey the code.

Based on a consensus panel process the societies recommend maintaining the existing WRVU value of 0.55. The societies recommend 15 minutes of physician intra-service time. The recommended value is less than the 25th percentile value from the survey data.

Survey Process
The survey was electronically disseminated to 114 practicing gastroenterologists, pulmonologists, and thoracic surgeons. A total of 17 responses (14.9% response rate) were received.

Work and Physician Time Recommendation Development – Consensus Panel Approach
Code +96570 was surveyed at the same time as +96571. An expert panel comprised of representatives from the Pulmonary, Gastroenterology, and Thoracic Surgery societies was convened to review the survey data. The panel had significant concerns with the survey data. Although a ZZZ code typically has only intra-service physician time associated with it, all of the survey respondents included pre and post physician time in their responses. The panel could not identify pre and/or post service work of the surveyed code to explain the survey times. In addition, the panel could not explain a median response of 40 minutes intra-service time for a surveyed procedure which was defined as taking up to 15 minutes. The panel concluded that the survey respondents either included pre- and/or post- time associated with the bronchoscopy / endoscopy procedure that is performed with the surveyed code, or that the respondents did not understand the RUC survey process.

After considering numerous options, the panel was unable to accurately link time and RVUs from the survey data. The panel concluded that the survey data was flawed and unusable. ***A consensus was reached to dismiss the data and develop work and physician time recommendations based on a consensus panel approach.***

A Note on the Moderate Sedation Survey Question
Moderate sedation is NOT inherent to the PDT. Rather, it is inherent to the base procedure (esophagoscopy, bronchoscopy). The panel of experts concluded that a high number of survey respondents indicated that it was inherent to +96571 due to confusion on the part of survey respondents.

Time Recommendation Development
Code +96570 is a ZZZ code that is performed with an endoscopy or bronchoscopy procedure. The endoscopy or bronchoscopy is performed in order for the physician to gain access for the photodynamic therapy. Code +96571 describes the continuation of the services described by code +96570. Code +96570 represents the first 30 minutes of the photodynamic therapy (PDT) service and code +96571 represents each additional 15 minutes of the PDT service. The expert panel agreed that there was no pre or post service work unique to the PDT that was not associated with the separately billed endoscopy / bronchoscopy procedure.

Based on these factors the panel concluded that 15 minutes of intra-service physician time was an appropriate and reasonable recommendation for code +96571.

Work Recommendation Development
Lacking usable survey data for code +96570, the expert panel had established a WRVU value of 1.10 using a crosswalk methodology. Code +96570 describes 30 minutes of photodynamic therapy and code +96571 is a continuation of this service representing each additional 15 minutes of treatment. Since +96571 represents 50% of the treatment time of +96570, the panel recommended that a fair and reasonable approach in determining a WRVU value for +96571 would be to recommend 50% of the WRVU value that was established for code +96570. This results in a value of 0.55 WRVU for code +96571. The Panel could not identify a compelling reason to change the current WRVU value of 0.55 for code +96571.

In view of the above, the societies recommend 0.55 WRVUs and physician time of 15 minutes (intra-service), with zero minutes of pre- or post-service time, for code +96571.

SERVICES REPORTED WITH MULTIPLE 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. SCENARIO A - Reported with code 31641, Bronchoscopy (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy) AND +96570, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minute

	CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
3.							
4.	31641	000	5.02	HARVARD	48	70	23
5.	+96570	ZZZ	1.10	RUC	0	50	0
6.							

7. SCENARIO B - Reported with code 43228, Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique AND +96570, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minute

	CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
8.							
9.	43228	000	3.76	HARVARD	45	40	23
10.	+96570	ZZZ	1.10	RUC	0	50	0
11.							

12. SCENARIO C – Reported with code 43258, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique AND +96570, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minute

	CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
13.							
14.	43258	000	4.54	RUC	21	46	20
15.	+96570	ZZZ	1.10	RUC	0	50	0
16.							

17. SCENARIO D – Reported with code 43272, Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique AND +96570, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minute

	CODE #	GLOBAL	WRVU	TIME SOURCE	PRE TIME	INTRA TIME	POST TIME
18.							
19.	43272	000	7.38	RUC	25	60	20
20.	+96570	ZZZ	1.10	RUC	0	50	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) +96571, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy bronchoscopy procedures of lung and esophagus)

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 Pulmonology How often? Rarely

Specialty Thoracic Surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 55
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 data received from the National Council for Prescription Drug Programs (NCPDP)

Specialty Thoracic surgery Frequency 5 Percentage 9.09 %

Specialty Gastroenterology Frequency 23 Percentage 41.81 %

Specialty Pulmonology Frequency 25 Percentage 45.45 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 22
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2007 Medicare utilization data

Specialty Thoracic surgery Frequency 2 Percentage 9.09 %

Specialty Gastroenterology Frequency 9 Percentage 40.90 %

Specialty Pulmonology Frequency 10 Percentage 45.45 %

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. 96571

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2009

Remote Diabetic Retinopathy Imaging

The American Academy of Ophthalmology (AAO) requested that code 9917X *Remote retinal imaging with interpretation and report (eg, diabetic retinopathy), bilateral*, which was recently approved by the CPT Editorial Panel in February 2009, be rescinded at this time. The AAO indicated that after surveying this code to develop a relative work value, they found that the respondents identified two distinct levels in this developing service. The specialty society requests to go back to the CPT Editorial Panel with a new coding proposal separating this service into two codes in order to identify the two approaches to remote retinal imaging. **The RUC recommends that CPT rescind code 9917X and the specialty society will develop a new coding proposal. Note: The CPT Executive Committee rescinded 9917X at its May 2009 Meeting.**

489

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•9917X	NN1	Remote retinal imaging with interpretation and report (eg, diabetic retinopathy), bilateral (Do not report 9917X in conjunction with 92135 or 92250. This service may not be used in addition to a general ophthalmological service, 92002-92014 or with the evaluation and management of the visual system, 99201-99350)	XXX	Recommend CPT rescind this code and specialty society will develop a new coding proposal
92135		Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral (For remote retinal imaging, use 9917X)	XXX	0.35 (No Change)
92250		Fundus photography with interpretation and report (For remote retinal imaging, use 9917X)	XXX	0.44 (No Change)

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

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Federal Affairs Department

March 30, 2009

Ms. Sherry Smith
Director, AMA RUC
American Medical Association
515 North State Stree
Chicago, IL 60610

Dear Ms.Smith:

The American Academy of Ophthalmology (the Academy) is writing to request that the code that was recently approved by the CPT Editorial Panel at its February 2009 Panel meeting, ***9917X*** *Remote retinal imaging with interpretation and results*, be withdrawn at this time, for submission of a recommended work value at the April 2009 RUC meeting. In surveying this code to develop a relative work value, the Academy has found that the respondents identified two distinct levels of service in this developing model of care.

We would like to bring a revised application back to the Panel that would correctly identify these two approaches to remote imaging. We expect to work on this with the American Optometric Association and other related organizations in preparation for a revised submission to the AMA CPT Editorial Panel this fall.

Thank you for your consideration.

Sincerely,

Steve Kamenetzky

Stephen Kamenetzky, M.D.
AAO RUC Advisor

cc: Michael Chaglasian, O.D.
AOA HCPAC Advisor

AMERICAN ACADEMY OF OPHTHALMOLOGY
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Federal Affairs Department

March 24, 2009

Ms. Marie Mindeman
Director, AMA CPT Editorial Panel
American Medical Association
515 North State Stree
Chicago, IL 60610

Dear Ms. Mindeman:

The American Academy of Ophthalmologists (the Academy) is writing to request that the code that was recently approved by the Editorial Panel at its February 2009 Panel meeting, ***9917X*** *Remote retinal imaging with interpretation and results*, be withdrawn at this time, for submission of a modified descriptor at an upcoming CPT Editorial Panel meeting. In surveying this code to develop a relative work value, the Academy has found that the respondents identified two distinct levels of service in this developing model of care. We would like to bring a revised application back to the Panel that would correctly identify these two approaches to remote imaging. We expect that we could have that ready for submission by the July deadline for the October 2009 meeting.

Thank you for your consideration.

Sincerely,

Michael X. Repka, M.D.
AAO CPT Advisor

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008

Prolonged Services Revision

The RUC considered code descriptor modification to CPT codes 99358 and 99359, which describe non face-to-face prolonged services. The RUC agreed with the specialty societies that the June 2008 revisions made by the CPT Editorial Panel to these codes reflect an editorial change in the description of the services and do not represent a change in the physician work involved in furnishing them. These codes are used to describe non face-to-face time that is provided beyond that listed in the CPT book as the typical time for an E/M service code. CPT 99358 is used to describe the first hour of such service and CPT 99359 is used to describe each additional 30 minutes. The CPT Editorial Panel change specifies that the non-face-to-face time need not be provided on the same date as the initial E/M service, but must be provided on a single date (i.e. not added up over many days). The work itself is not changed, merely the date on which it is provided. A change in global period would typically require a RUC survey, however, in this case a change from a ZZZ global code to an XXX global code without any pre- or post- time does not appear to necessitate a survey. Without a change in time or a change in work, these are the same services described in the current codes. **In summary, the RUC agreed that this change be considered editorial and does not require a survey. However, the RUC recommends that the vignette for these services be changed to reflect the current service:**

An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. She is brought to the primary care office by her daughter and has been seen and examined by the physician. The physician indicated that past medical records would be obtained from the patient's prior physicians' and that he will communicate further with the daughter upon review of them.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+▲99358	D1	**Prolonged evaluation and management service** before and/or after direct (face-to-face) patient care ~~(eg, review of extensive records and tests, communication with other professionals and/or the patient/family)~~; first hour ~~(List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient~~	~~ZZZ~~ XXX	2.10 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
		~~Evaluation and Management service)~~		
+▲99359	D2	each additional 30 minutes (List separately in addition to code for prolonged physician service) *(Use 99359 in conjunction with code 99358)* ~~(To report telephone evaluation and management services, see 99441-99443)~~	ZZZ	1.00 (No Change)

494

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from the Five Year Review

April 2009

Adjacent Tissue Transfer

CPT code 14300 *Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area* was identified by the Five Year Review Identification Workgroup as potentially misvalued through its site of service anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. Subsequent to being identified through the site of service anomaly screen, this code was identified through the CMS Fastest Growing Procedures Screen. The specialty societies agreed that the descriptor for this code did not accurately describe the work that is involved in the service as it did not differentiate between large and small defects therefore, the specialty society requested and the RUC agreed that the service be referred to CPT to clarify this issue. To address this concern the CPT Editorial Panel deleted CPT code 14300 and established two new codes to report adjacent tissue transfer of small and large defects.

495

14301 ***Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm***

The RUC reviewed the survey times for 14301 and questioned the additional 7 minutes of time added to the pre-service time package selected. The specialty societies explained that they added additional positioning time because these defects are occurring more frequently on difficult parts of the body including the face and hand and therefore the physician requires more time to position the particular body part to gain appropriate access to the surgical site. Based on this rationale, the RUC agreed that the additional positioning time associated with this service best reflected the pre-service time for this procedure. The RUC compared the surveyed code to its reference 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 noted that the surveyed code has more intra-service time as compared to the reference code, 100 minutes and 60 minutes respectively. Further, the RUC compared the surveyed code to another reference code MPC Code 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (Work RVU=12.08). The RUC noted that the surveyed code has slightly more time than this reference code, 100 minutes and 90 minutes respectively. Further, the RUC compared the intensity complexity measurements of the surveyed code and the reference code and determined that the surveyed code

requires more mental effort and judgment, more technical skill and physical effort to perform than the reference code. After making these comparisons, the specialty society explained that they did not have any compelling evidence to validate a higher work RVU for this service and therefore agreed that the impact of this code and 14302 need to be work neutral. Therefore based on utilization assumptions presented in the table below, the RUC agreed with the specialty societies recommended value of 12.47 work RVUs which is a value between the 25th percentile and the median. **The RUC recommends 12.47 Work RVUs for 14301.**

14302 ***Adjacent tissue transfer or rearrangement, any area; each additional 30 sq cm, or part thereof***

The RUC compared the surveyed code to its reference code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (Work RVU=4.88). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 40 minutes and 52 minutes respectively. Further, the RUC compared the intensity complexity measurements of the surveyed code and the reference code and determined that the reference code requires more mental effort and judgment and more physical effort to perform than the surveyed code. After making these comparisons, the specialty society explained that they did not have any compelling evidence to validate a higher work RVU for this service and therefore agreed that the impact of this code and 14302 need to be work neutral. Therefore based on utilization assumptions presented in the table below, the RUC agreed with the specialty societies recommended value of 3.73 work RVUs, the survey median. **The RUC recommends 3.73 Work RVUs for 14302. The RUC requested that this code be reviewed in the future to review the volume of this service to ensure that the utilization assumptions were accurate. Therefore the RUC added the code to the New Technology List solely to review claims data to ensure only 15% of these services are reported with the add-on code.**

4996

Work Neutrality Table

	RVW	Percentage	Utilization	Total RVUs
Current Data				
14300	13.26		14,138	**187,470 (Current RVUs)**
Projected Data				
14301 (100% of current utilization for 30-60 sq cm defects)	**12.47**	100.00%	14,138	176396
14302*1 (10% will be 60-90 sq cm defects)	**3.73**	10.00%	1,414	5273
14302*2 (4% will be 90-120 sq cm defects – requiring 14302 reported twice in addition to the base code)	7.46	4.00%	566	4219
14302*3 (1% will be 120-150 sq cm defects – requiring 14302 reported thrice in addition to the base code)	11.19	1.00%	141	1582
				187,470 (Projected RVUs)

PLI Crosswalks:
The RUC recommended that 14301 be crosswalked to the existing PLI of 14300 as they agree this is the most appropriate crosswalk.

Practice Expense:
The RUC reviewed the specialty societies' practice expense inputs for these services and with the exception of the addition of a medical supply recommend the proposed practice expense inputs which include practice expense inputs in the facility and non-facility setting for 14301 and no practice expense inputs for 14302 as it is typically performed in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Work RVU Recommendation
For full thickness repair of lip or eyelid, see respective anatomical subsections. Codes 14000~~-14300~~ 14302 are used for excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty rotation flap, advancement flap~~, double pedicle flap~~). When applied in repairing lacerations, the procedures listed must be performed by the surgeon to accomplish the repair. They do not apply to direct closure or rearrangement of traumatic wounds incidentally resulting in these configurations. Undermining alone of adjacent tissues to achieve closure, without additional incisions, does not constitute adjacent tissue transfer, see complex repair- 13100- ~~13153,~~13160. The excision of a benign lesion (11400-11446) or a malignant lesion (11600-11646) is not separately reportable with codes 14000~~-14300~~ 14302.			
D 14300		~~Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area~~	N/A
•14301	R1	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm	12.47
•+14302	R2	each additional 30 sq cm, or part thereof (List separately in addition to code for primary procedure) (Use 14302 in conjunction with 14301) (14300 has been deleted. To report, use 14301, 14302)	3.73

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:14301 Tracking Number R1 Specialty Society Recommended RVU: **12.47**

Global Period: 090 RUC Recommended RVU: **12.47**

CPT Descriptor: Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old female with an excised basal cell carcinoma on the left medial cheek leaves a defect through the subcutaneous plane that is 9.0 sq cm. A cheek rotation flap that is 42.0 sq cm is raised adjacent to the defect. The flap is transposed into the defect to achieve closure. The donor site is closed primarily.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 52% , In the ASC 3%, In the office 44%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 38% , Kept overnight (less than 24 hours) 44% , Admitted (more than 24 hours) 19%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 71%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 25%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

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

Description of Pre-Service Work: Determine indication for intra-operative antibiotics and prescribe as necessary. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Monitor/assist with positioning of patient. 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: The lesion is excised and then oriented and marked with sutures for pathologic examination. Hemostasis is obtained. Care is taken to determine the availability of adjacent tissue for closure and the possibility of functional impairment or anatomic distortion of adjacent structures. A flap is designed on the adjacent cheek skin. The flap is incised and raised at the appropriate level. The flap is rotated into the defect. Tension is assessed and additional dissection performed as necessary. The donor site is closed in layers. Drains are placed necessary. The flap is sutured into position.

Description of Post-Service Work:
Facility: A sterile dressing is applied. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note. Monitor patient stabilization in the recovery room. After patient is

awake, discuss surgery outcome with patient. Examine patient to assess for the development of complications (eg, bleeding). Dictate operative report (copy PCP and/or referring physician) and complete medical record documentation. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions, especially activity, bathing. Reconcile medications and write orders for post-discharge medication. Complete all appropriate medical records, including discharge summary and discharge instructions, and insurance forms.

Office: Examine and talk with patient. At several office visits, dressings will be removed and the wound will be assessed for flap compromise or compromise of structures adjacent to the flap (eg, eyes). The wound will be redressed. Drain(s) and sutures are removed, when appropriate. Pathology report is discussed when available. Write prescription orders, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Keith Brandt, MD; Brett Coldiron, MD; Jane Dillon, MD, FACS; and Christopher Senkowski, MD, FACS				
Specialty(s):	Plastic Surgery, Dermatology, Otolaryngology, and General Surgery				
CPT Code:	14301				
Sample Size:	250	**Resp N:** 61	**Response:** 24.4 %		
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	12.00	35.00
Survey RVW:	8.50	11.00	**13.50**	15.00	19.70
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**100.00**	120.00	260.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	14301	**Recommended Physician Work RVU: 12.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**100.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

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

New Technology/Service:

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
14060	090	9.07	**RUC Time**

CPT Descriptor Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm 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	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 26.2 %

TIME ESTIMATES (Median)	**CPT Code: 14301**	**Key Reference CPT Code:** 14060	**Source of Time** RUC Time
Median Pre-Service Time	58.00	30.00	
Median Intra-Service Time	100.00	60.00	
Median Immediate Post-service Time	25.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
`Median Discharge Day Management Time	19.0	0.00	
edian Office Visit Time	85.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**287.00**	**183.00**	
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	3.69	2.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.94	2.31
Urgency of medical decision making	2.50	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.69	3.19
Physical effort required	2.94	2.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.63	3.00
Outcome depends on the skill and judgment of physician	3.75	3.38
Estimated risk of malpractice suit with poor outcome	2.69	2.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.31	2.50
Intra-Service intensity/complexity	3.81	3.00
Post-Service intensity/complexity	2.81	2.31

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 adjacent tissue transfer (ATT) family of codes were identified by the RUC 5YR ID Workgroup as having a site of service anomaly. The descriptor for 14300 was identified as not accurately describing the work that is involved in this service. Additionally, ASPS noted that the 14300 descriptor includes multiple regions of the body, thus the individual circumstances can vary with respect to site of service.

A survey of plastic surgeons, dermatologists, otolaryngologists, and general surgeons was conducted for 14301. A consensus committee of specialists from these four disciplines reviewed the survey data.

With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: No change from standard 33 minutes.
- Positioning: Many different positions are possible for 143X1. Given the variability in positioning, we are recommending an additional 7 minutes for a total of 10 minutes, recognizing that this may not capture the time for all possible positioning.
- Scrub/Dress/Wait: No change from standard 15 minutes.

We agree with the median response that this patient would be discharged on the same day as the procedure. Consistent with the survey data, we recommend 4 post-office visits at the following levels:

- 99213 – Evaluation for flap compromise or compromise of structures adjacent to the flap (e.g., eyes)
- 99213 – Removal of drains; check viability of flap (e.g., arterial flow); wound assessment
- 99213 – Removal of sutures and explanation of pathology report
- 99212 – Check flap viability and wound healing

Code 14300 was split into two codes 143X1 and 143X2. Without compelling evidence, the recommendations need to be work neutral. The consensus committee discussed how often 143X2 would be used in multiples of 1, 2, or 3 and agreed with estimates of 10%, 4% and 1% respectively. This would account for ATT up to 150 sq cm. After that size, it was agreed that anything larger would most likely require another type of closure. Additionally, **the consensus committee agreed with the median survey RVW of 3.73 for 143X2,** as appropriately reflecting the more complex work of the larger ATT. Using the percentage 143X2 estimates, the recommended RVW for 143X2, and the current Medicare utilization for 14300, **we arrive at a work-neutral recommendation of 12.70 work RVUs for 143X1,** as presented in the table below:

CPT			2007 Util	RVW	Work RVUs
14300	Current RVW and Util		14,138	13.26	187,470

CPT	*Estimated* Utilization		Est Util	Rec RVW	Work RVUs
143X1	100% of current util for 30-60 sq cm	100%	14,138	12.70	179,553
143X2	10% will be 60-90 sq cm	10%	1,414	3.73	5,273
143X2	4% will be 90-120 sq cm	4%	566	3.73	2,109
143X2	1% will be120-150 sq cm	1%	141	3.73	527
					187,463

SERVICES REPORTED WITH MULTIPLE 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) 14300

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

Specialty Dermatology How often? Commonly

Specialty Plastic Surgery How often? Commonly

Specialty General Surgery/Otolaryngology How often? Sometimes

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

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? 14,138 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Untilization for 143X1 will be 100% of the current utilization for 14300 per 2007 Medicare data.

Specialty Dermatology Frequency 6221 Percentage 44.00 %

Specialty Plastic Surgery Frequency 4684 Percentage 33.13 %

Specialty General Surgery/Otolaryngology Frequency 2581 Percentage 18.25 %

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. 14300 is currently used to bill this procedure and is the most appropriate crosswalk

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:14302 Tracking Number R2 Specialty Society Recommended RVU: **3.73**

Global Period: ZZZ RUC Recommended RVU: **3.73**

CPT Descriptor: Adjacent tissue transfer or rearrangement, any area; each additional 30 sq cm, or part thereof

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old female with an excised squamous cell carcinoma on the left medial cheek leaves a defect through the subcutaneous plane that is 16.0 sq cm. A cervicofacial flap that is 72.0 sq cm is elevated adjacent to the defect. The flap is transposed into the defect to achieve closure. The donor site is closed primarily.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 82% , In the ASC 18%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 29% , Kept overnight (less than 24 hours) 29% , Admitted (more than 24 hours) 43%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 63%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 9%

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

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

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Additional lesion excision is carried out. Hemostasis is obtained. Continued care is taken to determine the availability of adjacent tissue for closure and the possibility of functional impairment or anatomic distortion of adjacent structures. The larger flap is incised and raised at the appropriate level. The larger flap is rotated into the defect. Tension is assessed and additional dissection performed as necessary. The additonal donor site is closed in layers. Drains may be placed. The larger flap is sutured into position.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Keith Brandt, MD; Jane Dillon, MD, FACS; and Christopher Senkowski, MD, FACS				
Specialty(s):	Plastic Surgery, Otolaryngology, and General Surgery				
CPT Code:	14302				
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	**3.00**	6.00	120.00
Survey RVW:	1.60	2.56	**3.73**	4.23	8.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	31.00	**40.00**	50.00	120.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	14302	**Recommended Physician Work RVU: 3.73**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

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

Modifier -51 Exempt Status

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

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

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49568	ZZZ	4.88	**RUC Time**

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

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

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

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

Other Reference CPT Code	Global	Work RVU	Time Source
CPT Descriptor			

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

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 17.6 %

TIME ESTIMATES (Median)	**CPT Code: 14302**	**Key Reference CPT Code: 49568**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	40.00	52.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**52.00**	
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	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.17
Urgency of medical decision making	3.33	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	3.50
Physical effort required	3.50	3.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.17
Outcome depends on the skill and judgment of physician	4.50	3.83
Estimated risk of malpractice suit with poor outcome	3.33	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.83	2.83
Intra-Service intensity/complexity	4.00	3.50
Post-Service intensity/complexity	2.50	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 adjacent tissue transfer (ATT) family of codes were identified by the RUC 5YR ID Workgroup as having a site of service anomaly. The descriptor for 14300 was identified as not accurately describing the work that is involved in this service. Additionally, ASPS noted that the 14300 descriptor includes multiple regions of the body, thus the individual circumstances can vary with respect to site of service.

Code 14300 was split into two codes 143X1 and 143X2. Without compelling evidence, the recommendations need to be work neutral. The consensus committee discussed how often 143X2 would be used in multiples of 1, 2, or 3 and agreed with estimates of 10%, 4% and 1% respectively. This would account for ATT up to 150 sq cm. After that size, it was agreed that anything larger would most likely require another type of closure. Additionally, **the consensus committee agreed with the median survey RVW of 3.73 for 143X2,** as appropriately reflecting the more complex work of the larger ATT. Using the percentage 143X2 estimates, the recommended RVW for 14302, and the current Medicare utilization for 14300, we arrive at a work-neutral recommendation of 12.70 work RVUs for 14301, as presented in the table below:

CPT			2007 Util	RVW	Work RVUs
14300	Current RVW and Util		14,138	13.26	187,470

CPT	*Estimated* Utilization		Est Util	Rec RVW	Work RVUs
143X1	100% of current util for 30-60 sq cm	100%	14,138	12.70	179,553
143X2	10% will be 60-90 sq cm	10%	1,414	3.73	5,273
143X2	4% will be 90-120 sq cm	4%	566	3.73	2,109
143X2	1% will be120-150 sq cm	1%	141	3.73	527
					187,463

SERVICES REPORTED WITH MULTIPLE 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) 14300

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

Specialty Plastic Surgery How often? Sometimes

Specialty General Surgery How often? Sometimes

Specialty Otolaryngology How often? Sometimes

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,121 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 15% of cases currently billable as 14300 will now be billed as 143X2.

Specialty Plastic Surgery	Frequency 1273	Percentage 60.01 %
Specialty General Surgery	Frequency 425	Percentage 20.03 %
Specialty Otolaryngology	Frequency 319	Percentage 15.04 %

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

CPT Code: 14301

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

CPT Long Descriptor:

CPT	DESCRIPTION	GLOB
14301	**Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm**	090

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

The facility practice expense details were discussed by a consensus committee of plastic surgeons, dermatologists, otolaryngologists, and general surgeons representing a variety of practice types and geographic settings.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carried out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities:

Discharge management (standard 6 minutes for same day) and standard office visit related activities are performed.

CPT Code: 14301

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

CPT Long Descriptor:

CPT	DESCRIPTION	GLOB
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm	090

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

The direct non-facility practice expense details were discussed by a consensus committee of plastic surgeons, dermatologists, otolaryngologists, and general surgeons representing a variety of practice types and geographic settings.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carried out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:

Clincal staff reviews the chart to be certain all pre-procedure testing and images are available and the H&P is current. The patient will be greeted and gowned and vital signs obtained. The procedure is reviewed. The procedure room is prepared, making certain supplies and equipment necessary are available. Clinical staff assists the physician with prepping, positioning, and providing anesthesia. This is a sterile procedure therefore, once the clinical staff is gloved, they will remain in the room and assist the physician with the entire procedure. After completion of the procedure, clinical staff will monitor the patient; clean the room; clean the surgical instruments; prepare diagnostic forms and send the excised specimen to pathology (if applicable); check dressings; and provide instructions on wound care, follow-up visits, and prescriptions.

Post-Service Clinical Labor Activities:
Standard office visit related activities are performed.

Details regarding medical supplies and equipment are provided in the attached spreadsheet.

	A	B	C	D	E	F	G
1	**Meeting Date: April 2009**			**14301**		**14302**	
2	**AMA/Specialty Society RVS Update Recommedation**			**Adjacent tissue transfer 30-60 sq cm**		**Adjacent tissue transfer each additional 30 sq cm**	
3	**LOCATION**	**Code**	**Staff Type**	**Office**	**FAC**	**Office**	**FAC**
4	**GLOBAL PERIOD**			**090**	**090**	**ZZZ**	**ZZZ**
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**300**	**201**	**0**	**0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**35**	**60**	**0**	**0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**130**	**6**	**0**	**0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**135**	**135**	**0**	**0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**		
12	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**10**	**20**		
13	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**8**		
14	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**10**	**20**		
15	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**10**	**7**		
17	**End:When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters site for procedure: Services Prior to Procedure**						
20	Review charts	**L037D**	RN/LPN/MTA				
21	Greet patient and provide gowning	**L037D**	RN/LPN/MTA	**3**			
22	Obtain vital signs	**L037D**	RN/LPN/MTA	**3**			
23	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA				
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**			
25	Setup scope (non facility setting only)	**L037D**	RN/LPN/MTA				
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**			
27	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA				
28	**Intra-service**						
29	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**100**			
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**1**			
32	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**			
33	Clean Scope	**L037D**	RN/LPN/MTA				
34	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**10**			
35	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA	**3**			
36	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**3**			
38	Discharge day management	**L037D**	RN/LPN/MTA	**0**	**6**		
40	**End: Patient leaves office**						
41	**POST-SERVICE Period**						
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions			**0**	**0**		
44	*Office visits:*						
45	*List Number and Level of Office Visits*						
46	99211 16 minutes		16				
47	99212 27 minutes		27	**1**	**1**		
48	99213 36 minutes		36	**3**	**3**		
49	99214 53 minutes		53				
50	99215 63 minutes		63				
52	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**135**	**135**		
54	**End: with last office visit before end of global period**						

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8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**135**	**135**	**0**	**0**
55	**MEDICAL SUPPLIES**	**Code**	**Unit**				
56	pack, minimum multi-specialty visit	**SA048**	**pack**	**5**	**4**		
57	pack, post-op incision care (suture)	**SA054**	**pack**	**1**	**1**		
58	scrub brush (impregnated)	**SM023**	**item**	**2**			
59	mask, surgical	**SB033**	**item**	**2**			
60	gloves, sterile	**SB024**	**pair**	**2**			
61	gown, staff, impervious	**SB027**	**item**	**2**			
62	blade, surgical hair clipper	**SF010**	**item**	**1**			
63	povidone surgical scrub (Betadine)	**SJ042**	**ml**	**10**			
64	povidone soln (Betadine)	**SJ041**	**ml**	**20**			
65	drape, sterile, for Mayo stand	**SB012**	**item**	**1**			
66	drape, sterile barrier 16in x 29in	**SB007**	**item**	**1**			
67	drape-towel, sterile OR blue (2 pk uou)	**SB020**	**item**	**2**			
68	drape, sterile barrier 16in X 29in	**SB007**	**item**	**1**			
69	skin marking pen, sterile (Skin Skribe)	**SK075**	**item**	**1**			
70	swab-pad, alcohol	**SJ053**	**item**	**2**			
71	lidocaine 1% w-epi inj (Xylocaine w-epi)	**SH046**	**ml**	**40**			
72	needle, 18-27g	**SC029**	**item**	**5**			
73	needle, 30g	**SC031**	**item**	**5**			
74	syringe, 3 ml	**SC055**	**item**	**5**			
75	sodium chloride 0.9% irrigation (500-1000ml uou)	**SH069**	**item**	**1**			
76	scalpel with blade, surgical (#10-20)	**SF033**	**item**	**1**			
77	suture, nylon, 3-0 to 6-0, c	**SF036**	**item**	**3**			
78	suture, vicryl, 3-0 to 6-0, p, ps	**SF040**	**item**	**3**			
79	cautery, monopolar, pencil-handpiece	**SF020**	**item**	**1**			
80	cautery, patient ground pad w-cord	**SF021**	**item**	**1**			
81	tray, suturing	**SA069**	**tray**	**1**			
82	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**item**	**2**			
83	bacitracin oint (15gm uou)	**SJ008**	**item**	**1**			
84	tape, surgical paper 1in (Micropore)	**SG079**	**inch**	**24**			
85	steri-strip (6 strip uou)	**SG074**	**item**	**2**			
86	dressing, 3inx4in (Telfa, Release)	**SG035**	**item**	**2**			
87	dressing, 5in x 9in (ABD-Combine)	**SG039**	**item**	**1**			
88	pack, cleaning, surgical instruments	**SA043**	**pack**	**1**			
89	cup, biopsy-specimen sterile 4oz	**SL036**	**item**	**1**			
90	**Equipment**	**Code**					
91	table, power	**EF031**		**265**	**135**		
92	light, surgical	**EF014**		**265**	**135**		
93	instrument pack, medium	**EQ138**		**130**			
94	mayo stand	**EF015**		**130**			
95	electrocautery-hyfrecator, up to 45 watts	**EQ110**		**130**			
96	camera, digital (6 mexapixel)	**ED004**		**5**			

RUC Recommendations for CPT 2010 Volume II

RUC Meetings October 2008, February 2009 and April 2009

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2010

TABLE OF CONTENTS

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five Year Review

February 2009

Excision of Soft Tissue and Bone Tumors

Background:
The American Academy of Orthopaedic Surgery (AAOS) and the Musculoskeletal Tumor Society (MSTS) responded to the Centers for Medicare and Medicaid Services' (CMS) Five-Year Review request for comment on misvalued codes in 1995, arguing that the Hsaio survey had misvalued these services. During the course of this first Five-Year Review process, it became evident that coding changes would be necessary prior to revaluing these services. From 1995-2005, MSTS and AAOS drafted CPT proposals to address issues within the soft tissue tumor excision family and bone tumor family codes but these proposals were rejected by the CPT advisors and/or the CPT Editorial Panel. For the 2005 Five-Year Review, MSTS and AAOS submitted 14 soft tissue tumor codes and 12 bone tumor codes which were ultimately referred again to the CPT Editorial Panel for clarification and creation of new codes to differentiate the codes based on the size and depth of the tumor. In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup which revised and expanded the soft tissue tumor and bone tumor sections to more accurately describe the services being provided and address the concerns raised by the RUC during the Third Five-Year Review.

521

Subcutaneous Excision of Soft Tissue Tumor Codes
There are currently 10 CPT codes that describe subcutaneous excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes differentiated by the size of the excised lesion. These codes were never part of a Five-Year Review Process, however, the societies agreed that these codes needed to be consistent with the new coding convention of the subfascial and radical soft tumor excision codes. Between 75-150 general surgeons, otolaryngologists, orthopaedic surgeons, general and orthopaedic surgical oncologists, hand surgeons, plastic surgeons, foot and ankle orthopaedic surgeons, and podiatrists participated in the some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. In addition to this analysis, the specialty societies noted that because these codes were never part of a Five-Year

Review Process, they recommended and the RUC agreed that the recommendations for this family of codes should be work neutral. To account for this decision, the specialty societies reduced their recommendations by 2.88%.

Subfascial Excision of Soft Tissue Tumor Codes

There are currently 10 CPT codes that describe subfascial excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes differentiated by size of excised lesion. Nine of these 10 original codes were part of one or more Five-Year Review Processes. The single code not originally identified has very low volume. The RUC sympathized with the argument that there should be work valuation changes but requested that codes first be reviewed by the CPT Editorial Panel. Between 75-150 general surgeons, orthopaedic surgeons, general and orthopaedic surgical oncologists, foot and ankle surgeons, podiatrists, otolaryngologists, hand surgeons and plastic surgeons participated in some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia, positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked.. In addition to this analysis, the societies noted that 18 of the 20 codes were part of a previous Five-Year Review. The societies presented significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence includes: 1.) Evidence that incorrect assumptions were made in the previous valuation of the service because the Harvard review of these codes did not survey all of the specialties, especially the primary providers, who currently perform these services; and 2.) evidence that technology has changed the physician work because over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Based on this compelling evidence and so not to create rank order anomalies, the RUC agreed that the recommendations for the subfascial excision of soft tissue tumor codes did not have to be work neutral. The RUC reviewed the site of service for this family of codes and agreed with the specialty societies data which supported an overnight hospital stay for seven of the large subfascial codes and three of the small subfascial codes. However, to ensure proper rank order across all of the soft tissue tumor codes, the small subfascial excision of soft tissue tumor codes were reduced by 2.88%. Additionally, the RUC recommended significant decreases to the specialty societies' recommendations for the large subfascial tissue tumor codes to ensure proper rank order with the small subfascial excision services, as a primary difference between the small and large subfascial tumor codes was the difference in the intra-service time. The RUC agrees that this adjustment to the large subfascial tissue tumor codes accounts for the 2.88% reduction and maintains the appropriate relativity to the rest of the tumor excision codes.

Radical Excision of Soft Tissue Tumor Codes

There are currently 11 codes that describe radical excision of soft tissue tumors. For CPT 2010, these 11 codes have been split into 22 codes differentiated by size of excised lesion. Six of these 11 codes were part of one or more Five-Year Review Processes. The RUC

sympathized with the argument that there should be work valuation changes but requested that codes first be reviewed by the CPT Editorial Panel. The other five codes have very low volume and are either not performed or rarely performed by orthopaedic surgeons and thus were not included in their comment letters to CMS during the Five-Year Reviews. Between 100-120 general surgeons, otolaryngologists, plastic surgeons, orthopaedic surgeons, orthopaedic and surgical oncologists participated in some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia, positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. Further, the societies presented and the RUC agreed that there is significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence includes: 1.) Evidence that incorrect assumptions were made in the previous valuation of the service because the Harvard review of these codes did not survey all of the specialties who currently perform these services and 2.) Evidence that technology has changed the physician work because over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Further, for malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This advancement has allowed for increased ability to kill tumors in situ at a higher level. These tumors are typically asymptomatic and therefore attain large size before being excised. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. Based on this compelling evidence and so not to create rank order anomalies, the RUC agreed that the recommendations for the radical excision of soft tissue tumor codes did not have to be work neutral. However, to ensure proper rank order across all of the soft tissue tumor codes, the radical excision of soft tissue tumor codes were reduced by 2.88%.

523

New Codes for Excision of Soft Tissue Tumor Codes

In addition to these revisions to the existing code set, the CPT Editorial Panel created 4 new subcutaneous, 4 new subfascial and 2 new radical excision codes. These codes were created to fill in anatomic gaps in the coding convention for excision of soft tissue tumors. The specialty societies noted that CPT Assistant indicated excision of subcutaneous soft tissue tumors may be reported with benign or malignant lesion codes which have a 10 day global period or an unlisted services code. The specialty societies also noted that excision of deep subfascial tumors or radical soft tissue excision procedures would currently be reported with the unlisted code. However, to ensure proper rank order across all of the soft tissue tumor codes, these new excision of soft tissue tumor codes were reduced by 2.88%. In addition to this reduction, the RUC determined that further reductions should be made to two of the four new subfascial codes to keep in rank order with the recommendations from the other subfascial codes.

Frequency and Impact
The specialties had difficulty in estimating the frequency split for current codes and frequency estimates for new codes but made a best faith effort. The specialties stated that they made several assumptions given the fact that this section has been completely revised including new guidelines and instructions. The RUC appreciated the difficulty of this task and agreed with the specialties recommended utilization. **However, the RUC recommended that these services should be re-reviewed to determine the accuracy of these utilization assumption in three years at the September 2012 RUC meeting to allow for time to obtain two years of frequency data from Medicare (2010 and 2011).** The overall increased work impact of the RUC recommendations for these services, given the society recommended utilization assumptions, is minor.

Repairs Resulting from Excisions
The RUC discussed the issue of separately reporting complex wound repair when performing an excision of a tumor, as the current introductory language states including simple or intermediate repair is included. RUC members expressed concern about complex repair being reported separately with these procedures. After much deliberation, it was determined that these services would rarely require complex repair as defined in CPT codes 13100-13153. However, to alleviate the concern, the CPT Editorial Panel has been requested to add introductory language to this section of codes clarifying the components of complex repair and when it should be reported separately.

524

Practice Expense
The RUC extensively discussed of the clinical labor time associated with the services performed in the non-facility setting and reduced the clinical labor time for several services. In addition, the RUC carefully scrutinized the supplies and equipment and made adjustments to reflect treatment of the typical patient. The practice expense inputs recommended by the specialty in the facility setting were also reviewed and modified. The RUC recommends the attached direct practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Excision of subcutaneous soft tissue tumors (including simple or intermediate repair) involves the simple or marginal resection of tumors confined to subcutaneous tissue below the skin but above the deep fascia. These tumors are usually benign and are resected without removing a significant amount of surrounding normal tissue. Code selection is based on the location and size of the tumor. Code selection is determined by measuring the greatest diameter of the tumor plus that margin required for complete excision of the tumor. The margins refer to the most narrow margin required to adequately excise the tumor, based on the physician's judgment. The measurement of the tumor plus margin is made at the time of the excision. Appreciable vessel exploration and/or neuroplasty should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumor is included in the excision. ***Excision of fascial or subfascial soft tissue tumors*** (including simple or intermediate repair) involves the resection of tumors confined to the tissue within or below the deep fascia, but not involving the bone. These tumors are usually benign, are often intramuscular, and are resected without removing a significant amount of surrounding normal tissue. Code selection is based on size and location of the tumor. Code selection is determined by measuring the greatest diameter of the tumor plus that margin required for complete excision of the tumor. The margins refer to the most narrow margin required to adequately excise the tumor, based on the physician's judgment. The measurement of the tumor plus margin is made at the time of the excision. Appreciable vessel exploration and/or neuroplasty should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumor is included in the excision. Digital (ie, fingers and toes) subfascial tumors are defined as those tumors involving the tendons, tendon sheaths or joints of the digit. Tumors which simply abut but do not breach the tendon, tendon sheath or joint capsule are considered subcutaneous soft tissue tumors. ~~Digital (ie, fingers and toes) subfascial tumors are defined as those tumors involving the tendons, tendon sheaths or joints of the digit. Tumors which simply abut but do not breach the tendon, tendon sheath or joint capsule are considered subcutaneous soft tissue tumors.~~ ***Radical resection of soft tissue tumors*** (including simple or intermediate repair) involves the resection of the tumor with wide margins of normal tissue. Appreciable vessel exploration and/or neuroplasty repair or reconstruction (eg, adjacent tissue transfer[s], flap[s]) should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumor is included in the excision. Although these tumors may be confined to a specific layer (eg, subcutaneous, subfascial), radical resection may involve removal of tissue from one or more layers. Radical resection of soft tissue tumors is most commonly used for malignant tumors or very aggressive benign tumors. Code selection is based on size and location of the tumor. Code selection is determined by measuring the greatest diameter of the tumor plus that margin required for complete excision of the tumor. The margins refer to the most narrow margin required to adequately excise the tumor, based on the physician's judgment. The measurement of the tumor plus margin is made at the time of the excision. For radical resection of tumors of cutaneous origin, (eg, melanoma) see 11600-11646. ***Radical resection of bone tumors*** (including simple or intermediate repair) involves the resection of the tumor with wide margins of normal tissue. Appreciable vessel exploration and/or neuroplasty and complex bone repair or reconstruction (eg, adjacent tissue transfer[s], flap[s]) should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumor is included in the excision. It may require removal of the entire bone if tumor growth is extensive (eg, clavicle). Radical resection of bone tumors is usually performed for malignant tumors or very aggressive benign tumors. If surrounding soft tissue is removed during these procedures, the radical resection of soft tissue tumor codes should not be reported separately. Code selection is based solely on the location of the tumor, **not** on the size of the tumor or whether the tumor is benign or malignant, primary or metastatic.				
Head				

525

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Excision				
●21011	P1	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	090	2.91
●21012	P2	2 cm or greater	090	4.37
●21013	P3	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	090	5.34
●21014	P4	2 cm or greater	090	7.00
▲21015	P5	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm	090	9.71
●21016	P6	2 cm or greater	090	15.05
▲21555	P7	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	090	3.88
●21552	P8	3 cm or greater	090	6.41
▲21556	P9	Excision, tumor, soft tissue of neck or anterior thorax~~; deep,~~ subfascial (eg, intramuscular); less than 5 cm	090	7.53
●21554	P10	5 cm or greater	090	11.00
▲21557	P11	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm	090	14.57
●21558	P12	5 cm or greater	090	21.37
Back and Flank Excision				

526

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲21930	P13	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	090	4.86
●21931	P14	3 cm or greater	090	6.80
●21932	P15	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	090	9.71
●21933	P16	5 cm or greater	090	11.00
▲21935	P17	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm	090	15.54
●21936	P18	5 cm or greater	090	22.34
Abdomen Excision				
●22902	P19	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	090	4.34
●22903	P20	3 cm or greater	090	6.31
▲22900	P21	Excision, tumor, soft tissue of abdominal wall tumor, subfascial (eg, desmoid intramuscular); less than 5 cm	090	8.21
●22901	P22	5 cm or greater	090	10.00
●22904	P23	Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm	090	16.51
●22905	P24	5 cm or greater	090	21.37
Shoulder Excision				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●23075	P25	Excision, ~~soft tissue~~ tumor, soft tissue, of shoulder area, subcutaneous; less than 3 cm	090	4.13
●23071	P26	3 cm or greater	090	5.83
▲23076	P27	Excision, tumor, soft tissue of tumor shoulder area~~;~~ , ~~deep,~~ subfascial ~~or~~ (eg, intramuscular); less than 5 cm	090	7.28
●23073	P28	5 cm or greater	090	10.00
▲23077	P29	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm	090	17.48
●23078	P30	5 cm or greater	090	22.34
▲23200	P31	Radical resection ~~for~~ of tumor; clavicle	090	22.50
▲23210	P32	scapula	090	27.00
▲23220	P33	Radical resection of ~~bone~~ tumor, proximal humerus~~;~~	090	30.00
D 23221		~~with autograft (includes obtaining graft)~~	090	N/A
D 23222		~~with prosthetic replacement~~ (23221, 23222 have been deleted)	090	N/A
Humerus (Upper Arm) and Elbow Excision				
▲24075	P34	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3	090	4.16

528

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		cm		
●24071	P35	3 cm or greater	090	5.62
▲24076	P36	Excision, tumor, soft tissue of upper arm or elbow area, ~~deep (~~subfascial ~~or~~ (eg, intramuscular); less than 5 cm	090	7.28
●24073	P37	5 cm or greater	090	10.00
▲24077	P38	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm	090	15.54
●24079	P39	5 cm or greater	090	20.40
▲24150	P40	Radical resection ~~for~~ of tumor, shaft or distal humerus~~;~~	090	23.25
D 24151		~~with autograft (includes obtaining graft)~~	090	N/A
▲24152	P41	Radical resection ~~for~~ of tumor, radial head or neck~~;~~	090	19.78
D 24153		~~with autograft (includes obtaining graft)~~ (24151, 24153 have been deleted)	090	N/A
Forearm and Wrist Excision				
▲25075	P42	Excision, tumor, soft tissue of forearm and/or wrist area~~,~~ subcutaneous; less than 3 cm	090	3.88
●25071	P43	3 cm or greater	090	5.83
▲25076	P44	Excision, tumor, soft tissue of forearm and/or wrist area~~,~~; ~~deep (~~ subfascial ~~or~~ (eg,	090	6.61

529

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		intramuscular); less than 3 cm		
●25073	P45	3 cm or greater	090	7.00
▲25077	P46	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm	090	12.75
●25078	P47	3 cm or greater	090	17.48
▲25170	P48	Radical resection ~~for~~ of tumor, radius or ulna	090	22.00
Hand and Fingers Excision				
▲26115	P49	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5	090	3.88
●26111	P50	1.5 cm or greater	090	5.34
▲26116	P51	Excision, tumor, or vascular malformation, soft tissue of hand or finger,~~; deep~~ subfascial ~~or~~ (eg, intramuscular); less than 1.5 cm	090	6.61
●26113	P52	1.5 cm or greater	090	7.00
▲26117	P53	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm	090	9.95
●26118	P54	3 cm or greater	090	14.57
▲26250	P55	Radical resection of tumor, metacarpal ~~(eg, tumor);~~	090	15.00

530

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 26255		~~with autograft (includes obtaining graft)~~	090	N/A
▲26260	P56	Radical resection of tumor, proximal or middle phalanx of finger ~~(eg, tumor);~~	090	11.00
D 26261		~~with autograft (includes obtaining graft)~~	090	N/A
▲26262	P57	Radical resection of tumor, distal phalanx of finger (eg, tumor) (26255, 26261 have been deleted)	090	8.13
Pelvis and Hip Joint Excision				
▲27047	P58	Excision, tumor, soft tissue of pelvis and hip area, ~~;~~ subcutaneous ~~tissue~~; less than 3 cm	090	4.86
●27043	P59	3 cm or greater	090	6.80
▲27048	P60	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	090	8.74
●27045	P61	5 cm or greater	090	11.00
▲27049	P62	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area ~~(eg, malignant neoplasm)~~; less than 5 cm	090	21.37
●27059	P63	5 cm or greater	090	29.14
▲27075	P64	Radical resection of tumor ~~or infection~~; wing of ilium, one pubic or ischial ramus or symphysis pubis	090	32.50

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲27076	P65	ilium, including acetabulum, both pubic rami, or ischium and acetabulum	090	40.00
▲27077	P66	innominate bone, total	090	45.00
▲27078	P67	ischial tuberosity and greater trochanter of femur	090	32.00
D 27079		~~ischial tuberosity and greater trochanter of femur, with skin flaps~~ (27079 has been deleted)	090	N/A
Femur (Thigh Region) and Knee Joint Excision				
▲27327	P68	Excision, tumor, soft tissue of thigh or knee area~~;~~, subcutaneous; less than 3 cm	090	3.88
●27337	P69	3 cm or greater	090	5.83
▲27328	P70	Excision, tumor, soft tissue of thigh or knee area~~;deep~~, subfascial ~~or~~ (eg, intramuscular); less than 5 cm	090	8.74
●27339	P71	5 cm or greater	090	11.00
▲27329	P72	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm	090	15.54
●27364	P73	5 cm or greater	090	24.28
▲27365	P74	Radical resection of tumor, ~~bone,~~ femur or knee	090	32.00
Leg (Tibia and Fibula) and Ankle Joint Excision				
▲27615	P75	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm	090	15.54

532

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●27616	P76	5 cm or greater	090	19.42
▲27618	P77	Excision, tumor, soft tissue of leg or ankle area~~;~~, subcutaneous ~~tissue~~; less than 3 cm	090	3.88
●27632	P78	3 cm or greater	090	5.83
▲27619	P79	Excision, tumor, soft tissue of leg or ankle area~~;deep (~~subfascial ~~or~~ (eg, intramuscular); less than 5 cm	090	6.80
●27634	P80	5 cm or greater	090	10.00
▲27645	P81	Radical resection of tumor~~, bone~~; tibia	090	27.00
▲27646	P82	fibula	090	23.00
▲27647	P83	talus or calcaneus	090	20.10
Foot and Toes Excision				
▲28046	P84	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3	090	12.20
●28047	P85	3 cm or greater	090	17.24
▲28043	P86	Excision, tumor, soft tissue of foot or toe, subcutaneous ~~tissue~~; less than 1.5 cm	090	3.88
●28039	P87	1.5 cm or greater	090	5.34
▲28045	P88	Excision, tumor, soft tissue of foot or toe~~,; deep~~ subfascial (eg, intramuscular); less than 1.5 cm	090	5.34

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●28041	P89	1.5 cm or greater	090	7.00
▲28171	P90	Radical resection of tumor~~, bone~~; tarsal (except talus or calcaneus)	090	16.25
▲28173	P91	metatarsal	090	14.00
▲28175	P92	phalanx of toe	090	8.13

534

Subcutaneous Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
21555	P7	090	3.88	The RUC reviewed the survey data for CPT code 215X0 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm and compared it with its reference code 11642 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm (Work RVU=2.57) and MPC code 11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm (Work RVU=4.29). The RUC noted that the surveyed code had less intra-service time than the MPC code, 35 minutes and 45 minutes, respectively and that the surveyed code had more intra-service time that the reference code, 35 minutes and 25 minutes, respectively. Further, the RUC noted that the surveyed code required more technical skill, mental effort and judgment to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 3.88 RVUs for 215X0, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 215X0.
215X1	P8	090	6.41	The RUC reviewed the survey data for CPT code 215X1 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69) and MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (Work RVU=5.51). The RUC noted that the surveyed code had more total time than the MPC code, 194 minutes and 187 minutes, respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Further, the RUC noted that the surveyed code required less psychological stress and less urgency of decision making than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 6.41 RVUs for 215X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 6.41 Work RVUs for 215X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
21930	P13	090	4.86	The RUC reviewed the survey data for CPT code 21930 Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm and compared it with its reference code, MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (Work RVU=4.97). The RUC noted that the surveyed code and the reference code had similar total service times, 165 minutes and 153 minutes, respectively. The RUC noted that the surveyed code required more technical skill to perform and creates more psychological stress than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code the RUC recommends 4.86 RVUs for 21930, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.86 Work RVUs for 21930.
219X1	P14	090	6.80	The RUC reviewed the survey data for CPT code 219X1 Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater and compared it with its reference code, 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). The RUC noted that the surveyed code had more intra-service time than the reference code, 60 minutes and 45 minutes, respectively and more total service time than the reference code, 206 minutes and 178 minutes respectively. Further, the RUC noted that the surveyed code requires more physical effort to perform and creates more psychological stress than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.80 RVUs for 219X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 6.80 Work RVUs for 219X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
23075	P25	090	4.13	The RUC reviewed the survey data for CPT code 230X0 Excision, soft tissue tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time that the reference code, 142 minutes and 113 minutes, respectively. Further, the RUC noted that the surveyed code required more technical skill, mental effort and judgment to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 230X0, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.13 Work RVUs for 230X0.
230X1	P26	090	5.83	The RUC reviewed the survey data for CPT code 230X1 Excision, soft tissue tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code and the reference code had similar total service times, 191 minutes and 181 minutes respectively. Further, the RUC noted that the surveyed code and the reference code had similar intensity and complexity measurements with the reference code causing slightly more psychological stress. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code, the RUC recommends 5.83 RVUs for 230X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 230X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
24075	P34	090	4.16	The RUC reviewed the survey data for CPT code 240X0 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time than the reference code, 142 minutes and 113 minutes respectively. Further, the RUC noted that the surveyed code required more mental effort, judgment, technical skill and physicial effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code, the RUC recommends 4.16 RVUs for 240X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.16 Work RVUs for 240X0.
240X1	P35	090	5.62	The RUC reviewed the survey data for CPT code 240X1 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90) and MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (Work RVU=4.97). Despite similar intensity and complexity measurements, the RUC noted that the surveyed code had less intra-service time as compared to the reference code, 45 minutes and 50 minutes, respectively and that the surveyed code had more total service time than the MPC code, 183 minutes and 153 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 5.62 RVUs for 240X1, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.62 Work RVUs for 240X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
25075	P42	090	3.88	The RUC reviewed the survey data for CPT code 250X0 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time than the reference code, 137 minutes and 113 minutes respectively. Further, the RUC noted that the surveyed code required more technical skill and overall was a more intense procedure to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 250X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 250X0.
250X1	P43	090	5.83	The RUC reviewed the survey data for CPT code 250X1 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code and the reference code had similar total service times, 178 minutes and 181 minutes respectively. Further, the RUC noted that the surveyed code and the reference code had very similar intensity and complexity measurement with the reference code requiring slightly more physical effort to perform in comparison to the surveyed code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.83 RVUs for 250X1, which is a value between the 25th percentile and the surveyed median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 250X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
26115	P49	090	3.88	The RUC reviewed the survey data for CPT code 261X0 Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code had less total service time than the reference code, 137 minutes and 181 minutes respectively. Further, the RUC noted that the surveyed code requires less technical skill, physical effort and overall was a less intense procedure to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 261X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 261X0.
261X1	P50	090	5.34	The RUC reviewed the survey data for CPT code 261X1Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater and compared it with its reference code, 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90) and MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (work RVU=5.51). Although, the intensity and complexity measures of the surveyed code and the reference code are the same, the RUC noted that the surveyed code had less intra-service time than the reference code and the MPC code, 40 minutes, 50 minutes and 60 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 5.34 RVUs for 261X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.34 Work RVUs for 261X1.

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
27047	P58	090	4.86	The RUC reviewed the survey data for CPT code 270X0 Excision, tumor, soft tissue of pelvis and hip area, subcutaneous tissue; less than 3 cm and compared it with its reference code, 46040 Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)(Work RVU=5.26) and MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (work RVU=4.97). The RUC noted that the surveyed code had less total service time than the reference code, 160 minutes and 184 minutes, respectively and that the surveyed code had similar total service time that the reference code, 160 minutes and 153 minutes, respectively. Further, the RUC noted that the surveyed code required less mental effort and judgment to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 4.86 RVUs for 270X0, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.86 Work RVUs for 270X0.
270X1	P59	090	6.80	The RUC reviewed the survey data for CPT code 270X1 Excision, tumor, soft tissue of pelvis and hip area, subcutaneous tissue; 3 cm or greater and compared it with its reference code, 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). The RUC noted that the surveyed code had more intra-service time than the reference code, 60 minutes and 45 minutes, respectively and more total service time than the reference code, 206 minutes and 178 minutes respectively. Further, the RUC noted that the surveyed code required more technical skill, physical effort to perform and creates more psychological stress than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.80 RVUs for 270X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 6.80 Work RVUs for 270X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27327	P68	090	3.88	The RUC reviewed the survey data for CPT code 273X0 Excision, tumor, soft tissue of thigh or knee area;, subcutaneous; less than 3 cm and compared it with its reference code 11622 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm(Work RVU=2.36). The RUC noted that the surveyed code had more total service time than the reference code, 140 minutes and 87 minutes respectively. Further, the RUC noted that the surveyed code requires more technical skill and overall was a more intense procedure to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 273X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 273X0.
273X1	P69	090	5.83	The RUC reviewed the survey data for CPT code 273X1Excision, tumor, soft tissue of thigh or knee area;, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code and the reference code had the same total service times, 181 minutes. Further, the RUC noted that the surveyed code and the reference code had similar intensity and complexity measurements with the reference code requiring slightly more technical skill and physical effort to perform in comparison to the surveyed code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.83 RVUs for 273X1, which is a value between the 25th percentile and the surveyed median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 273X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27618	P77	090	3.88	The RUC reviewed the survey data for CPT code 276X0 Excision, tumor, soft tissue of leg or ankle area;, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time than the reference code, 137 minutes and 113 minutes respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment and overall was a more intense procedure to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 276X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 276X0.
276X1	P78	090	5.83	The RUC reviewed the survey data for CPT code 276X1 Excision, tumor, soft tissue of leg or ankle area;, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90) and MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (Work RVU=4.97). The RUC noted that the surveyed code and the reference codes had very similar total service times, 183 minutes and 181 minutes, respectively and that the surveyed code had more total service time than the MPC code, 183 minutes and 153 minutes, respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 5.83 RVUs for 276X1, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 276X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
28043	P86	090	3.88	The RUC reviewed the survey data for CPT code 280X0 Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm and compared it with its reference code 11422 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm (Work RVU=1.65). The RUC noted that the surveyed code had significantly more total service time than the reference code, 138 minutes and 56 minutes respectively. Further, the RUC noted that the surveyed code required more technical skill and physical effort to perform than the reference code. In addition the RUC compared the surveyed code to another reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47) and noted that the surveyed code has more total service time than this reference code, 138 minutes and 113 minutes respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 280X0, which is a value between the 25th percentile and the surveyed median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 280X0.
280X1	P87	090	5.34	The RUC reviewed the survey data for CPT code 280X1 Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater 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 surveyed code had less total-service time than the reference code, 153 minutes and 197 minutes, respectively. Further, the RUC noted that the surveyed code required more technical skill, physical effort to perform and creates more psychological stress to perform than the reference code. Further, the RUC compared the surveyed code to MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (Work RVU=5.51) and noted that the surveyed code has significantly more total time than the surveyed code, 187 minutes and 153 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.34 RVUs for 280X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.34 Work RVUs for 280X1.

Subfascial Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
21556	P9	090	7.53	The RUC reviewed the survey data for CPT code 215X2 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69). The RUC noted that the surveyed code has more total service time than the reference code, 234 minutes and 152 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment and technical skill to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.53 RVUs for 215X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.53 Work RVUs for 215X2.
215X3	P10	090	11.00	The RUC reviewed the survey data for CPT code 215X3 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 38700 Suprahyoid lymphadenectomy (Work RVU=12.68). The RUC noted that although the surveyed code and the reference code have the same intra-service time, 90 minutes, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the survey 25th percentile, 11.00 RVUs for 215X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 11.00 Work RVUs for 215X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
22900	P21	090	8.21	The RUC reviewed the survey data for CPT code 22900 Excision, tumor, soft tissue of abdominal wall tumor, subfascial (eg, desmoid intramuscular); less than 5 cm and compared it with its reference code 49505 Repair initial inguinal hernia, age 5 years or older; reducible (Work RVU=7.88). The RUC reviewed the survey data and agreed with the specialty society that a hospital visit and full day discharge visit were appropriate as majority of survey respondents who stated that they typically perform this procedure in the hospital stated that the patient is kept overnight or admitted. In addition, the RUC noted that the surveyed code as compared to the reference code has more total service time (244 minutes and 198 minutes). Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 8.21 RVUs for 22900, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 8.21 Work RVUs for 22900.
229X2	P22	090	10.00	The RUC reviewed the survey data for CPT code 229X2 Excision, tumor, soft tissue of abdominal wall tumor, subfascial (eg, desmoid intramuscular); 5 cm or greater and compared it with its reference code 49560 Repair initial incisional or ventral hernia; reducible (Work RVU=11.84). The RUC noted that although the surveyed code and the reference code have the same intra-service time, 90 minutes, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors (Work RVU=9.89). The RUC agreed that 25115 was a better reference because the surveyed code and 25115 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 90 minutes and 3.) the 25115 reference code has slightly less total service time as compared to the surveyed code, 257 minutes and 284 minutes. Due to these comparisons between the surveyed code and the 25115 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 10.00 RVUs, a value below the surveyed 25th percentile, for 229X2. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 229X2.

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
23076	P27	090	7.28	The RUC reviewed the survey data for CPT code 230X2 Excision, tumor, soft tissue of tumor shoulder area; deep, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 13132 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm (Work RVU=6.48). The RUC noted that the surveyed code as compared to the reference code has more intra-service time (60 minutes and 45 minutes) and more total service time (221 minutes and 136 minutes). Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.28 RVUs for 230X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.28 Work RVUs for 230X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
230X3	P28	090	10.00	The RUC reviewed the survey data for CPT code 230X3 Excision, tumor, soft tissue of tumor shoulder area; deep, subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 29828 Arthroscopy, shoulder, surgical; biceps tenodesis (Work RVU=13.00). The RUC determined that the pre-service time package selected by the specialty society did not accurately reflect the pre-service time to perform the procedure. Therefore, the RUC modified the pre-service package associated with this service to pre-service time package three as the RUC agreed that the vignette described a more staightforward patient. Further, the RUC noted that although the surveyed code and the reference code have the same intra-service time, 75 minutes, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula (Work RVU=10.01). The RUC agreed that 27832 was a better reference because the surveyed code and 27832 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 75 minutes and 3.) the 27832 reference code has very similar total service times as compared to the surveyed code, 301 minutes and 297 minutes. Due to these comparisons between the surveyed code and the 27832 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the surveyed 25th percentile,10.00 RVUs, for 230X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 230X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
24076	P36	090	7.28	The RUC reviewed the survey data for CPT code 240X2 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code as compared to the reference code has more intra-service time (60 minutes and 40 minutes) and more total service time (229 minutes and 191 minutes). Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.28 RVUs for 240X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.28 Work RVUs for 240X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
240X3	P37	090	10.00	The RUC reviewed the survey data for CPT code 240X3 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater 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 determined that the pre-service time package selected by the specialty society did not accurately reflect the pre-service time to perform the procedure. Therefore, the RUC modified the pre-service package associated with this service to pre-service time package three as the RUC agreed that the vignette described a more straightforward patient. Further, the RUC noted that although the surveyed code has less total service time than the reference code, 295 minutes and 358 minutes, respectively, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula (Work RVU=10.01). The RUC agreed that 27832 was a better reference because the surveyed code and 27832 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 75 minutes and 3.) the 27832 reference code has very similar total service times as compared to the surveyed code, 301 minutes and 295 minutes. Due to these comparisons between the surveyed code and the 27832 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 10.00 RVUs, a value below the surveyed 25th percentile, for 240X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 240X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
25076	P44	090	6.61	The RUC reviewed the survey data for CPT code 250X2 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code and the reference code have very similar intra-service times (45 minutes and 40 minutes, respectively and total service times (206 minutes and 191 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.61 RVUs for 250X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 6.61 Work RVUs for 250X2.
250X3	P45	090	7.00	The RUC reviewed the survey data for CPT code 250X3 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater and compared it with its reference code 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors (Work RVU=9.89). The RUC noted that the surveyed code has less intra-service time than the reference code, 60 minutes and 90 minutes, respectively. During its discussion, the RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 38520 Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad (Work RVU=6.95). The RUC agreed that 38520 was a better reference because the surveyed code and the 38520 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 60 minutes and 3.) the 38520 reference code has slightly less total service time as compared to the surveyed code, 193 minutes and 221 minutes. Due to these comparisons between the surveyed code and the 38520 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 7.00 RVUs, a value below the surveyed 25th percentile, for 250X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.00 Work RVUs for 250X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
26116	P51	090	6.61	The RUC reviewed the survey data for CPT code 261X2 Excision, tumor, soft tissue, or vascular malformation, soft tissue of hand or finger; subfascial (eg, intramuscular); less than 1.5 cm and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code and the reference code have very similar intra-service times (45 minutes and 40 minutes, respectively and total service times (201 minutes and 191 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.61 RVUs for 261X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 6.61 Work RVUs for 261X2.
261X3	P52	090	7.00	The RUC reviewed the survey data for CPT code 280X3 Excision, tumor, soft tissue, or vascular malformation, soft tissue of hand or finger; subfascial (eg, intramuscular); 1.5 cm or greater and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code as compared to the reference code has more intra-service time (58 minutes and 40 minutes, respectively and total service time (214 minutes and 191 minutes, respectively). Furthermore the RUC noted that the surveyed code requires greater mental effort and judgment to perform than the surveyed code. However, the RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Due to these comparisons between the surveyed code and the reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 7.00 RVUs, a value slightly higher than the surveyed 25th percentile for 261X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.00 Work RVUs for 261X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27048	P60	090	8.74	The RUC reviewed the survey data for CPT code 270X2 Excision, tumor, soft tissue of pelvis and hip area subfascial (eg, intramuscular); less than 5 cm and compared it 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). The RUC noted that when comparing the surveyed code to 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), the surveyed code has more total service time than this MPC reference code, 288 minutes and 223 minutes . Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 8.74 RVUs for 270X2, which is a value between 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 8.74 Work RVUs for 270X2.
270X3	P61	090	11.00	The RUC reviewed the survey data for CPT code 270X3 Excision, tumor, soft tissue of pelvis and hip area subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 47100 Biopsy of liver, wedge (Work RVU=12.78). The RUC noted that although the surveyed code has less total service time than the reference code, 320 minutes and 345 minutes, respectively. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the surveyed 25th percentile of 11.00 RVUs for 270X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 11.00 Work RVUs for 270X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27328	P70	090	8.74	The RUC reviewed the survey data for CPT code 273X2 Excision, tumor, soft tissue of thigh or knee area subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code and the reference code have similar intensity and complexity measures and the surveyed code as compared to the reference code has comparable total service time (261 minutes and 281 minutes). The RUC noted that when comparing the surveyed code to 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), the surveyed code has more total service time than this MPC reference code, 261 minutes and 223 minutes . Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 8.74 RVUs for 273X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 8.74 Work RVUs for 273X2.
273X3	P71	090	11.00	The RUC reviewed the survey data for CPT code 273X3 Excision, tumor, soft tissue of thigh or knee area subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that although the surveyed code has less total service time than the reference code, 310 minutes and 423 minutes, respectively, and agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 11.00 RVUs, a value below the surveyed 25th percentile, for 273X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 11.00 Work RVUs for 273X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27619	P79	090	6.80	The RUC reviewed the survey data for CPT code 276X2 Excision, tumor, soft tissue of leg or ankle area subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code has less total service time than the reference code, 225 minutes and 281 minutes, respectively. Further, the RUC noted that the reference code causes more psychological stress to perform than the surveyed code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.80 RVUs for 276X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 6.80 Work RVUs for 276X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
276X3	P80	090	10.00	The RUC reviewed the survey data for CPT code 276X3 Excision, tumor, soft tissue of leg or ankle area subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 28299 Excision, tumor, soft tissue of leg or ankle area subfascial (eg, intramuscular); (Work RVU=11.39). When reviewing the pre-service time packages, the RUC determined that the pre-service time package selected by the specialty society did not accurately reflect the pre-service time to perform the procedure. Therefore, the RUC modified the pre-service package associated with this service to pre-service time package three as the RUC agreed that the vignette described a more staightforward patient. Further, the RUC noted that although the surveyed code has less intra-service time than the reference code, 70 minutes and 90 minutes respectively, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula (Work RVU=10.01). The RUC agreed that 27832 was a better reference because the surveyed code and 27832 reference code have 1.) similar intensities of work, 2.) the similar intra-service times, 70 minutes and 75 minutes and 3.) the 27832 reference code has very similar total service times as compared to the surveyed code, 301 minutes and 293 minutes. Due to these comparisons between the surveyed code and the 27832 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the surveyed 25th percentile, 10.00 RVUs, for 276X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 276X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
28045	P88	090	5.34	The RUC reviewed the survey data for CPT code 280X2 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm and compared it with its reference code 13121 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm (Work RVU=4.36). The RUC noted that the surveyed code has more total service time than the reference code, 169 minutes and 117 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment and technical skill to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.34 RVUs for 280X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 5.34 Work RVUs for 280X2.
280X3	P89	090	7.00	The RUC reviewed the survey data for CPT code 280X3 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater and compared it with its reference code 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 although the surveyed code has less total service time than the reference code, 217 minutes and 227 minutes, respectively, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 38520 Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad (Work RVU=6.95). The RUC agreed that 38520 was a better reference because the surveyed code and the 38520 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 60 minutes and 3.) the 38520 reference code has slightly less total service time as compared to the surveyed code, 193 minutes and 217 minutes. Due to these comparisons between the surveyed code and the 38520 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 7.00 RVUs, a value between the 25th percentile and surveyed median, for 280X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.00 RVUs for Work 280X3.

Radical Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
21015	P5	090	9.71	The RUC reviewed the survey data for CPT code 21015 Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm and compared it with its reference code 38700 Suprahyoid lymphadenectomy (Work RVU=12.68). The RUC noted that the surveyed code as compared to the reference code has less intra service time (75 minutes and 90 minutes, respectively) and less total service time (277 minutes and 300 minutes). Further, the RUC noted that the surveyed code overall is a less intense procedure to perform than the reference code. In addition, the RUC compared the surveyed code to MPC code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code in comparison to the MPC code has similar total service times, 277 minutes and 281 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 9.71 RVUs for 21015, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 9.71 Work RVUs for 21015.
210X5	P6	090	15.05	The RUC reviewed the survey data for CPT code 210X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; 2 cm or greater and compared it with its reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code has slightly less total service time as compared to the reference code, 398 minutes and 407 minutes, respectively. In addition, the RUC compared the surveyed code to another reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that the surveyed code as compared to the reference code has very similar total service time (398 minutes and 400 minutes). Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 15.05 RVUs for 210X5, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.05 Work RVUs for 210X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
21557	P11	090	14.57	The RUC reviewed the survey data for CPT code 21557 Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm and compared it with its reference code 38700 Suprahyoid lymphadenectomy (Work RVU=12.68). The RUC noted that the surveyed code as compared to the reference code has more intra-service time, 113 minutes and 90 minutes, respectively and more total service time than the reference code, 398 minutes and 300 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment and more physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 14.57 RVUs for 21557, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 14.57 Work RVUs for 21557.
215X4	P12	090	21.37	The RUC reviewed the survey data for CPT code 215X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; 5 cm or greater and compared it with reference code 15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk (Work RVU=19.62). The RUC noted that although the surveyed code and the reference code have similar intra-service times, 160 minutes and 163 minutes, respectively, the surveyed procedure requires significantly more mental effort and judgment, technical skill, and physical effort to perform as compared to the reference code. In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code has more total service time as compared to the MPC code, 480 minutes and 447 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 21.37 RVUs for 215X4, which is a value between the 25th percentile and surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 21.37 Work RVUs for 215X4.

559

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
21935	P17	090	15.54	The RUC reviewed the survey data for CPT code 21935 Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm and compared it with its reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that the surveyed code as compared to the reference code has more intra service time (120 minutes and 80 minutes, respectively) and very similar total service time (408 minutes and 400 minutes). Further, the RUC noted that the surveyed code overall is a slightly more intense procedure to perform than the reference code. In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code and the reference code have very similar total service times, 408 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 21935, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 21935.
219X4	P18	090	22.34	The RUC reviewed the survey data for CPT code 219X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; 5cm or greater and compared it with its reference code 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less (Work RVU=20.00). The RUC noted that the surveyed code has more intra-service time than the reference code, 160 minutes and 120 minutes respectively and more total service time than the reference code, 510 minutes and 420 minutes, respectively . Further, the RUC noted that the surveyed code requires more mental effort and judgment, more technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 22.34 RVUs for 219X4, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 22.34 Work RVUs for 219X4.

560

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
23077	P29	090	17.48	The RUC reviewed the survey data for CPT code 23077 Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm and compared it with its reference code 23395 Muscle transfer, any type, shoulder or upper arm; single (Work RVU=18.29). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (140 minutes and 160 minutes, respectively). In addition, the RUC compared the surveyed code to another reference code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU=17.21). The RUC noted that the surveyed code in comparison to the reference code has more intra-service time, 140 minutes and 120 minutes and more total service times, 433 minutes and 394 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 17.48 RVUs for 23077, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 17.48 Work RVUs for 23077.
230X4	P30	090	22.34	The RUC reviewed the survey data for CPT code 230X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; 5 cm or greater and compared it with reference code 44140 Colectomy, partial; with anastomosis (Work RVU=22.46). The RUC noted that the surveyed code and the reference code have very similar total service times, 490 minutes and 480 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code has more intra-service time than the MPC code, 180 minutes and 150 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 22.34 RVUs for 230X4, which is a value between the 25th percentile and surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 22.34 Work RVUs for 230X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
24077	P38	090	15.54	The RUC reviewed the survey data for CPT code 240X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm and compared it with its reference code 23395 Muscle transfer, any type, shoulder or upper arm; single (Work RVU=18.29). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (120 minutes and 160 minutes, respectively). In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code in comparison to the reference code has similar total service times, 405 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 240X4, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 240X4.
240X5	P39	090	20.40	The RUC reviewed the survey data for CPT code 240X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; 5 cm or greater and compared it with reference code 44140 Colectomy, partial; with anastomosis (Work RVU=22.46). The RUC noted that the surveyed code has less total service time as compared to the reference code, 472 minutes and 480 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code and the MPC code have the same intra-service time, 150 minutes. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 20.40 RVUs for 240X5, which is a value between the 25th percentile and surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 20.40 Work RVUs for 240X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
25077	P46	090	12.75	The RUC reviewed the survey data for CPT code 25077 Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm and compared it with its reference code 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed (Work RVU=9.89). The RUC noted that the surveyed code as compared to the reference code has more intra-service time, 100 minutes and 90 minutes, respectively and more total service time than the reference code, 345 minutes and 257 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, more technical skill and overall is a much more intense procedure to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 12.75 RVUs for 25077, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 12.75 Work RVUs for 25077.
250X4	P47	090	17.48	The RUC reviewed the survey data for CPT code 250X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; 3 cm or greater and compared it with its reference code 24363 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) (Work RVU=22.47). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code has less total service time as compared to the reference code, 422 minutes and 466 minutes, respectively and less intra-service time, 120 minutes and 150 minutes respectively. In addition, the RUC compared the surveyed code to MPC code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU=17.21). The RUC noted that the surveyed code as compared to the reference code has more total service time, 422 minutes and 394 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 17.48 RVUs for 250X4, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 17.48 Work RVUs for 250X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
26117	P53	090	9.95	The RUC reviewed the survey data for CPT code 26117 Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm and compared it with its reference code 25447 Arthroplasty, interposition, intercarpal or carpometacarpal joints (Work RVU=10.95). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (75 minutes and 100 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code in comparison to the MPC code has more intra-service time, 75 minutes and 60 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 9.95 RVUs for 26117, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 9.95 Work RVUs for 26117.
261X4	P54	090	14.57	The RUC reviewed the survey data for CPT code 261X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; 3 cm or greater and compared it with its reference code 24363 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) (Work RVU=22.47). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (100 minutes and 150 minutes, respectively) and less total service time (368 minutes and 466 minutes). In addition, the RUC compared the surveyed code to another 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 noted that the surveyed code in comparison to this reference code has more total service time, 368 minutes and 358 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 14.57 RVUs for 261X4, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 14.57 Work RVUs for 261X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27049	P62	090	21.37	The RUC reviewed the survey data for CPT code 270X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; less than 5 cm and compared it with its reference code 47380 Ablation, open, of one or more liver tumor(s); radiofrequency (Work RVU=24.43). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (180 minutes and 200 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code in comparison to the MPC code has more intra-service time, 180 minutes and 150 minutes and more total service times, 496 minutes and 447 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 21.37 RVUs for 270X4, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 21.37 Work RVUs for 270X4.
270X5	P63	090	29.14	The RUC reviewed the survey data for CPT code 270X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater and compared it with its reference code 27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft (Work RVU=30.13). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (220 minutes and 240 minutes, respectively). In addition, the RUC noted that the surveyed code in comparison to the reference code has similar total service times, 608 minutes and 617 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 29.14 RVUs for 270X5, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 29.14 Work RVUs for 270X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27329	P72	090	15.54	The RUC reviewed the survey data for CPT code 273X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm 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). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less total service time (413 minutes and 469 minutes, respectively). In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code in comparison to the reference code has similar total service times, 413 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 273X4, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 273X4.
273X5	P73	090	24.28	The RUC reviewed the survey data for CPT code 273X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; 5cm or greater 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 noted that the surveyed code has more intra-service time than the reference code, 180 minutes and 124 minutes respectively and more total service time than the reference code, 550 minutes and 469 minutes, respectively . Further, the RUC noted that the surveyed code requires more mental effort and judgment, more technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 24.28 RVUs for 273X5, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 24.28 Work RVUs for 273X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27615	P75	090	15.54	The RUC reviewed the survey data for CPT code 27615 Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm and compared it with its reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that the surveyed code as compared to the reference code has more intra service time (120 minutes and 80 minutes, respectively) and very similar total service time (416 minutes and 400 minutes). Further, the RUC noted that the surveyed code overall is a slightly more intense procedure to perform than the reference code. In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code and the reference code have similar total service times, 416 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 27615, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 27615.
2761X	P76	090	19.42	The RUC reviewed the survey data for CPT code 2761X Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; 5 cm or greater and compared it with reference code 15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk(Work RVU=19.62). The RUC noted that the surveyed code has less total service time as compared to the reference code, 463 minutes and 524 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 23395 Muscle transfer, any type, shoulder or upper arm; single (Work RVU=18.29). The RUC noted that the surveyed code as compared to the MPC code has more total service time, 463 minutes and 423 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 19.42 RVUs for 2761X, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 19.42 Work RVUs for 2761X.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
28046	P84	090	12.20	The RUC reviewed the survey data for CPT code 28046 Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 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 surveyed code has more total service time than the reference code, 334 minutes and 299 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 12.20 RVUs for 28046, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 12.20 Work RVUs for 28046.
2804X	P85	090	17.24	The RUC reviewed the survey data for CPT code 2804X Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; 3 cm or greater 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). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code has less total service time as compared to the reference code, 413 minutes and 469 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU=17.21). The RUC noted that the surveyed code as compared to the reference code has the same intra-service time, 120 minutes and similar total service times (413 minutes and 394 minutes). Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 17.24 RVUs for 2804X, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 17.24 Work RVUs for 2804X.

New Codes for Excision Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
210X1	P1	090	2.91	The RUC reviewed the survey data for CPT code 210X1 Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm and compared it with its reference code 11642 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm (Work RVU=2.67). The RUC noted that although the surveyed code and reference code have very similar intensity and complexity measurements, the surveyed code as compared to the reference code had slightly more intra-service time (30 minutes and 25 minutes respectively and total service time (107 minutes and 68 minutes, respectively). The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 2.91 RVUs for 210X1, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 2.91 Work RVUs for 210X1.
210X2	P2	090	4.37	The RUC reviewed the survey data for CPT code 210X2 Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater and compared it with its reference code 11643 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm (Work RVU=3.37). The RUC noted that the surveyed code as compared to the reference code had more intra-service time (45 minutes and 30 minutes respectively and total service time (148 minutes and 93 minutes, respectively). Further, the RUC noted that the surveyed code required more technical skill and physical effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 4.37 RVUs for 210X2, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 4.37 Work RVUs for 210X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
210X3	P3	090	5.34	The RUC reviewed the survey data for CPT code 210X3 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69). The RUC noted that although the surveyed code and the reference code have the same intra-service times (45 minutes), the reference code in comparison to the reference code requires, more mental effort and judgment and physical effort to perform than the surveyed code. Furthermore, the RUC compared the surveyed code to MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (Work RVU=5.51). The RUC noted that the MPC code has more intra service time in comparison to the surveyed code, 60 minutes and 45 minutes respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the MPC code and the reference code, the RUC recommends 5.34 RVUs for 210X3, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 5.34 Work RVUs for 210X3.
210X4	P4	090	7.00	The RUC reviewed the survey data for CPT code 210X4 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69). The RUC noted that the surveyed code as compared to the reference code had more intra-service time (60 minutes and 45 minutes, respectively) and total service time (217 minutes and 152 minutes, respectively). Further, the RUC noted that the surveyed code required more technical skill and physical effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.00 RVUs for 210X4, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. Furthermore, this value is also consistent with the recommendations for the subfascial family of codes. The RUC recommends 7.00 Work RVUs for 210X4.

570

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
219X2	P15	090	9.71	The RUC reviewed the survey data for CPT code 219X2 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC reviewed the survey data and agreed with the specialty society that a hospital visit and full day discharge visit were appropriate as the majority of survey respondents who stated that they typically perform this procedure in the hospital stated that the patient is kept overnight or admitted. The RUC noted that the surveyed code and the reference code have very similar total service times (276 minutes and 281 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. In addition, the RUC compared the surveyed code to another reference code 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors (Work RVU=9.89). The RUC noted that the reference code has more intra service time in comparison to the surveyed code, 90 minutes and 60 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 9.71 RVUs for 219X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 9.71 Work RVUs for 219X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
219X3	P16	090	11.00	The RUC reviewed the survey data for CPT code 219X3 Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5cm or greater and compared it with its reference code 38745 Axillary lymphadenectomy; complete (Work RVU=13.71). The RUC reviewed the survey data and agreed with the specialty society that a hospital visit and full day discharge visit were appropriate as the majority of survey respondents who stated that they typically perform this procedure in the hospital stated that the patient is kept overnight or admitted. Further, the RUC noted that although the surveyed code has the same intra-service time as the reference code, 90 minutes, respectively, the RUC agreed that this was a poor reference code. Therefore, the RUC agreed that a better reference code and keeping consistent with other recommendations from the subfascial family of codes would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the recommendations for the subfascial codes, the RUC recommends 11.00 RVUs, a value below the surveyed 25th percentile, for 219X3. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. Furthermore, this value is also consistent with the recommendations for the subfascial family of codes. The RUC recommends 11.00 Work RVUs for 219X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
229X0	P19	090	4.34	The RUC reviewed the survey data for CPT code 229X0 Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm and compared it with its reference code 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). Although the surveyed code and the reference code have similar intensity and complexity measurements, the RUC noted that the surveyed code as compared to the reference code has less total service time (148 minutes and 178 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm (Work RVU=4.29). The RUC noted that the surveyed code had significantly more total service time in comparison to the MPC code, 148 minutes and 108 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 4.34 RVUs for 229X0, which is a value between the 25 percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 4.34 Work RVUs for 229X0.
229X1	P20	090	6.31	The RUC reviewed the survey data for CPT code 229X1 Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater and compared it with its reference code 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). The RUC noted that the surveyed code and the reference code have very similar intra-service times (50 minutes and 45 minutes, respectively and total service times (179 minutes and 178 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.31 RVUs for 229X1, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 6.31 Work RVUs for 229X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
229X3	P23	090	16.51	The RUC reviewed the survey data for CPT code 229X3 Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm and compared it with its reference code 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less (Work RVU=20.00). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less total service time (396 minutes and 420 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 19318 Reduction mammaplasty (Work RVU=15.91). The RUC noted that the surveyed code has more total service time than the reference code, 396 minutes and 321 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the MPC code and the reference code, the RUC recommends 16.51 RVUs for 229X3, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 16.51 Work RVUs for 229X3.
229X4	P24	090	21.37	The RUC reviewed the survey data for CPT code 229X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater and compared it with its reference code 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less (Work RVU=20.00). The RUC noted that the surveyed code as compared to the reference code had more intra-service time (150 minutes and 120 minutes, respectively) and total service time (463 minutes and 420 minutes, respectively). Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 21.37 RVUs for 229X4, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. Furthermore, this value is also consistent with the recommendations for the subfascial family of codes. The RUC recommends 21.37 Work RVUs for 229X4.

574

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21555 Tracking Number P7 Specialty Society Recommended RVU: **3.88**

Global Period: 090 RUC Recommended RVU: **3.88**

CPT Descriptor: Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male undergoes excision of a 2.5 cm lipoma on his neck.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Percent of survey respondents who stated they perform the procedure; In the hospital 82% , In the ASC 0%, In the office 18%

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

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

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

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

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

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning and adjusting the OR table and MAC lines so that the operative site is assessable. Clip hair from surgical site. 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, an incision is made through the skin and subcutaneous tissue of the neck overlying the mass. The tumor is identified and dissected free along the tumor capsule, taking care not to traumatize surrounding structures. The tumor is removed and sent for permanent pathologic evaluation. The wound is inspected and irrigated. After assuring complete hemostasis, the wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied to the neck. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery ıtcome with patient. Dictate operative report and complete medical record documentation. Communicate with other ,rofessionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week

and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS				
Specialty(s):	general surgery; otolaryngology				
CPT Code:	21555				
Sample Size: 75	**Resp N:** 30	**Response:** 40.0 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	6.00	25.00
Survey RVW:	2.00	3.19	**4.00**	6.00	10.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	30.00	**35.00**	45.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	21555	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**6.00**	**1.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11642	010	2.57	RUC Time

CPT Descriptor Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)	CPT Code: 21555	Key Reference CPT Code: 11642	Source of Time RUC Time
Median Pre-Service Time	30.00	15.00	
Median Intra-Service Time	35.00	25.00	
Median Immediate Post-service Time	15.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**138.00**	**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	2.10	1.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.20	2.00
Urgency of medical decision making	2.30	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.60	2.30
Physical effort required	2.40	2.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	2.50
Outcome depends on the skill and judgment of physician	2.70	2.80
Estimated risk of malpractice suit with poor outcome	2.70	2.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.40	2.00
Intra-Service intensity/complexity	2.20	2.00
Post-Service intensity/complexity	1.90	1.90

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.*

Current code 21555 (Excision tumor, soft tissue of neck or thorax; subcutaneous) will be deleted in 2010 and replaced by two new codes (P7 and P8).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: No change.

- Positioning: Add 5 minutes – after induction of anesthesia in supine position, adjusting the OR table and MAC lines so that the operative site is assessable. Clip hair from surgical site
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 3.88 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.027. The recommended RVW for this 90-day global code is greater than the reference code which is an office-based procedure with a 10-day global period and one post-op office visit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21555

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
lease explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21552 Tracking Number P8 Specialty Society Recommended RVU: **6.41**

Global Period: 090 RUC Recommended RVU: **6.41**

CPT Descriptor: Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male undergoes excision of an enlarging 5 cm tumor of the anterior thorax near the anterior axillary line.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 86% , Kept overnight (less than 24 hours) 14% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 75%

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

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

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

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. 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, an oblique incision is made through the skin and subcutaneous tissue overlying the mass. The tumor is identified and dissected free along the tumor capsule, taking care not to traumatize surrounding structures. The tumor is removed and sent for permanent pathologic evaluation. The wound is inspected and irrigated. After assuring complete hemostasis, the wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied to the chest. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surge outcome with patient. Dictate operative report and complete medical record documentation. Communicate with othe professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge

summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS				
Specialty(s):	general surgery; otolaryngology				
CPT Code:	21552				
Sample Size:	75	**Resp N:**	30	**Response:** 40.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**4.00**	6.00	15.00
Survey RVW:	4.04	6.00	**6.60**	7.13	12.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	45.00	**60.00**	60.00	90.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	21552	**Recommended Physician Work RVU: 6.41**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38510	010	6.69	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep cervical node(s)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 53.3 %

TIME ESTIMATES (Median)	**CPT Code: 21552**	**Key Reference CPT Code: 38510**	**Source of Time RUC Time**
Median Pre-Service Time	51.00	45.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	25.00	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	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**194.00**	**152.00**	
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	2.86	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.57
Urgency of medical decision making	2.71	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	2.86
Physical effort required	3.00	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.07	3.21
Outcome depends on the skill and judgment of physician	3.14	3.21
Estimated risk of malpractice suit with poor outcome	2.86	2.79

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.92	3.08
Intra-Service intensity/complexity	3.08	3.00
Post-Service intensity/complexity	2.38	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.*

Current code 21555 (Excision tumor, soft tissue of neck or thorax; subcutaneous) will be deleted in 2010 and replaced by two new codes (P7 and P8).

Pre-Time: With respect to the pre-service time, we recommend package 3 with no changes.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 6.41 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.049. The recommended RVW is similar to the reference code 38510 which has a 10-day global period, only one post-op office visit, and less intra-op time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 21555

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21930 Tracking Number P13 Specialty Society Recommended RVU: **4.86**

Global Period: 090 RUC Recommended RVU: **4.86**

CPT Descriptor: Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old female undergoes excision of a 2.5 cm spongy tumor on her back.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 90% , In the ASC 0%, In the office 10%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 95% , Kept overnight (less than 24 hours) 5% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery and hemostasis is controlled. The tumor is excised along with proper margin of tissue. Hemostasis is secured with electrocautery and sutures where needed. Small lymphatic channels are ligated. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain

medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order medications necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary.. Discuss progı with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology		
CPT Code:	21930		
Sample Size:	100	**Resp N:** 41	**Response:** 41.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**4.00**	7.00	15.00
Survey RVW:	2.00	4.47	**5.00**	6.00	10.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	45.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	21930	**Recommended Physician Work RVU: 4.86**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**18.00**	**1.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11606	010	4.97	**RUC Time**

CPT Descriptor Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 29.2 %

TIME ESTIMATES (Median)

	CPT Code: 21930	**Key Reference CPT Code: 11606**	**Source of Time RUC Time**
Median Pre-Service Time	42.00	30.00	
Median Intra-Service Time	45.00	90.00	
Median Immediate Post-service Time	20.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**165.00**	**153.00**	
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	2.08	2.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.08	2.08
Urgency of medical decision making	2.25	2.17

Technical Skill/Physical Effort (Mean)

Technical skill required	2.42	2.50
Physical effort required	2.33	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.58	2.75
Outcome depends on the skill and judgment of physician	2.75	2.83
Estimated risk of malpractice suit with poor outcome	2.83	2.58

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.08	2.25
Intra-Service intensity/complexity	2.17	2.08
Post-Service intensity/complexity	2.00	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.*

Current code 21930 (Excision, tumor, soft tissue of back or flank) will be deleted in 2010 and replaced by four new codes (P13, P14, P15, and P16). During the Harvard study, 12 general surgeons were surveyed only for intra-operative time. Pre and post times were predicted. This prediction resulted in no positioning time, no facility post-work (even though the code is typically performed in a facility), and one office visit (even though the procedure will typically require at least two office visits during the 90-day global period). The prediction also placed the details for

this code similar to the smallest subcutaneous excision details per the current survey (P13). The time and visit information for 21930 does not represent larger and/or deeper tumors. Further, without requiring a RUC survey in 1995 during the first 5-year-review, the code was reduced based on a comment letter.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 4.86 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.036. This is similar to the IWPUT for the reference code 11606, which has similar total time, but is an office-based procedure with a 10-day global period.

SERVICES REPORTED WITH MULTIPLE 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) 21930

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is not available.

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

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

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21931 Tracking Number P14 Specialty Society Recommended RVU: **6.80**

Global Period: 090 RUC Recommended RVU: **6.80**

CPT Descriptor: Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male undergoes excision of a 5 cm fatty tumor on his flank.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 83% , Kept overnight (less than 24 hours) 18% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 86%

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery to expose the lesion and hemostasis is controlled. The tumor is excised along with proper margin of tissue. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare

professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology		
CPT Code:	21931		
Sample Size:	100	**Resp N:** 41	**Response:** 41.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	5.00	12.00
Survey RVW:	3.50	6.00	**7.00**	8.75	13.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	40.00	**60.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	21931	**Recommended Physician Work RVU: 6.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38525	090	6.35	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep axillary node(s)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 21.9 %

TIME ESTIMATES (Median)	CPT Code: 21931	Key Reference CPT Code: 38525	Source of Time RUC Time
Median Pre-Service Time	68.00	45.00	
Median Intra-Service Time	60.00	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	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**206.00**	**178.00**	
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	2.78	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.89
Urgency of medical decision making	3.00	3.11

Technical Skill/Physical Effort (Mean)

Technical skill required	3.44	3.44
Physical effort required	3.11	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.44
Outcome depends on the skill and judgment of physician	3.67	3.56
Estimated risk of malpractice suit with poor outcome	3.56	3.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.11
Intra-Service intensity/complexity	3.11	3.22
Post-Service intensity/complexity	2.56	2.89

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.*

Current code 21930 (Excision, tumor, soft tissue of back or flank) will be deleted in 2010 and replaced by four new codes (P13, P14, P15, and P16). During the Harvard study, 12 general surgeons were surveyed only for intra-operative time. Pre and post times were predicted. This prediction resulted in no positioning time, no facility post-work (even though the code is typically performed in a facility), and one office visit (even though the procedure will typically require at least two office visits during the 90-day global period). The prediction also placed the details for

this code similar to the smallest subcutaneous excision details per the current survey (P13). The time and visit information for 21930 does not represent larger and/or deeper tumors. Further, without requiring a RUC survey in 1995 during the first 5-year-review, the code was reduced based on a comment letter.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 6.80 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.051. This is similar to the IWPUT for the reference code 38525, which has less intra-operative time and less total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 21930

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

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

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

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23075 Tracking Number P25 Specialty Society Recommended RVU: **4.13**

Global Period: 090 RUC Recommended RVU: **4.13**

CPT Descriptor: Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male undergoes excision of a 1.5 cm tumor overlying his deltoid muscle.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 97% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 0%

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

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with lateral beach chair positioning, exposing the shoulder and stabilizing the patient's torso. 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 4 cm incision is made in the skin and subcutaneous tissue over the shoulder. Medial and lateral flaps are made. Careful dissection is carried around the tumor. The tumor is excised and sent to pathology. Hemostasis is obtained. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate

medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Revise treatm plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	23075				
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	6.00	25.00
Survey RVW:	2.00	3.50	**4.25**	6.00	9.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	30.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	23075	**Recommended Physician Work RVU: 4.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11406	010	3.47	**RUC Time**

CPT Descriptor Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 25.7 %

TIME ESTIMATES (Median)	CPT Code: 23075	Key Reference CPT Code: 11406	Source of Time RUC Time
Median Pre-Service Time	34.00	20.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	20.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**142.00**	**113.00**	
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	2.22	2.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.22	2.11
Urgency of medical decision making	2.00	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.44	2.44
Physical effort required	2.11	2.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.11	2.22
Outcome depends on the skill and judgment of physician	2.67	2.67
Estimated risk of malpractice suit with poor outcome	2.44	2.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.11	1.89
Intra-Service intensity/complexity	2.44	1.89
Post-Service intensity/complexity	2.00	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.*

Current code 23075 (Excision, soft tissue tumor, shoulder area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P25 and P26). During the Harvard study, 13 orthopaedic surgeons were surveyed only for intra-operative time. General surgery, the primary provider of this service, was not involved. Additionally, the global period designated was 10-days. This was different than any other soft tissue code reviewed.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, the patient will be repositioned beach chair and slightly lateral to expose the shoulder and stabilizing the patient's torso.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 4.13 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.035. This is similar to the IWPUT for the reference code 11406, which has similar total time, but is an office based procedure with a 10-day global period.

SERVICES REPORTED WITH MULTIPLE 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) 23075

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23071 Tracking Number P26 Specialty Society Recommended RVU: **5.83**

Global Period: 090 RUC Recommended RVU: **5.83**

CPT Descriptor: Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43 year-old female undergoes a 3.5 cm tumor overlying her scapula.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 94% , Kept overnight (less than 24 hours) 6% , Admitted (more than 24 hours) 0%

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

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. 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 6 cm incision is made in the skin and subcutaneous tissue over the shoulder. Medial and lateral flaps are made. Careful dissection is carried around the tumor. The tumor is excised and sent to pathology. Hemostasis is obtained. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of f operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and comple medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate

medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	23071				
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**5.00**	8.00	25.00
Survey RVW:	4.00	4.75	**6.00**	8.00	12.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	38.00	**45.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	23071	**Recommended Physician Work RVU: 5.83**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 28.5 %

TIME ESTIMATES (Median)	**CPT Code: 23071**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	68.00	65.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**191.00**	**181.00**	
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	2.70	2.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.40	2.10
Urgency of medical decision making	2.40	2.11

Technical Skill/Physical Effort (Mean)

Technical skill required	2.80	2.60
Physical effort required	2.60	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	2.70
Outcome depends on the skill and judgment of physician	3.00	2.80
Estimated risk of malpractice suit with poor outcome	2.70	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.60	2.50
Intra-Service intensity/complexity	2.60	2.50
Post-Service intensity/complexity	2.30	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.*

Current code 23075 (Excision, soft tissue tumor, shoulder area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P25 and P26). During the Harvard study, 13 orthopaedic surgeons were surveyed only for intra-operative time. General surgery, the primary provider of this service, was not involved. Additionally, the global period designated was 10-days. This was different than any other soft tissue code reviewed.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 5.83 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.046. This RVW is similar to the reference code 20680, which has a 90-day global period and similar total time and total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23075

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each special
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24075 Tracking Number P34 Specialty Society Recommended RVU: **4.16**

Global Period: 090 RUC Recommended RVU: **4.16**

CPT Descriptor: Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female undergoes excision of a 2 cm tumor from the anterior aspect of the distal right arm.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 95% , Kept overnight (less than 24 hours) 5% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 4cm incision is made in the skin and subcutaneous tissue over the tumor. Careful dissection is carried around the tumor. The tumor is excised and sent to pathology. The tourniquet is deflated and any bleeders are cauterized. The wound is inspected and irrigated. The wound is closed in two layers with interrupted sutures.

escription of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take pecimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider

relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	24075				
Sample Size:	100	**Resp N:**	42	**Response:** 42.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	5.00	12.00
Survey RVW:	2.00	0.42	**5.00**	6.00	10.00
Pre-Service Evaluation Time:			**33.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	24075	**Recommended Physician Work RVU: 4.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11406	010	3.47	**RUC Time**

CPT Descriptor Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 26.1 %

TIME ESTIMATES (Median)	CPT Code: 24075	Key Reference CPT Code: 11406	Source of Time RUC Time
Median Pre-Service Time	34.00	20.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	20.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**142.00**	**113.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Iental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.45	1.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.36	2.09
Urgency of medical decision making	2.36	2.09
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.36	2.18
Physical effort required	2.09	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.36	2.45
Outcome depends on the skill and judgment of physician	2.73	2.55
Estimated risk of malpractice suit with poor outcome	2.82	2.45

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.09	1.73
Intra-Service intensity/complexity	1.91	1.64
Post-Service intensity/complexity	1.91	1.64

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.*

Current code 24075 (Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P34 and P35). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 4.16 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.036. This is slightly more than the IWPUT for the reference code 11406, which is an office-based procedure with a 10-day global period.

SERVICES REPORTED WITH MULTIPLE 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) 24075

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

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

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

Specialty	Frequency	Percentage	%
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.

ıdicate 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:24071 Tracking Number P35 Specialty Society Recommended RVU: **5.62**

Global Period: 090 RUC Recommended RVU: **5.62**

CPT Descriptor: Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female undergoes excision of a 4 cm tumor from the anterior aspect of the distal right arm.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 85% , Kept overnight (less than 24 hours) 15% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 67%

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 7 cm incision is made in the skin and subcutaneous tissue over the tumor. Careful dissection is carried around the tumor. The tumor is excised and sent to pathology. The tourniquet is deflated and any bleeders are cauterized. The wound is inspected and irrigated. The wound is closed in two layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Ta' specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist , coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider

relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	24071				
Sample Size:	100	**Resp N:**	42	**Response:** 42.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	5.00	19.00
Survey RVW:	3.00	5.79	**7.00**	8.00	18.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(3[illegible] 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

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

CPT Code:	24071	**Recommended Physician Work RVU: 5.62**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)	**CPT Code: 24071**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**183.00**	**181.00**	
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	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.38
Urgency of medical decision making	2.38	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.25	2.25
Physical effort required	2.00	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.38
Outcome depends on the skill and judgment of physician	2.63	2.38
Estimated risk of malpractice suit with poor outcome	2.63	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.13
Intra-Service intensity/complexity	2.38	2.00
Post-Service intensity/complexity	2.25	1.88

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.*

Current code 24075 (Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P34 and P35). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 5.62 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.045. This is similar to the IWPUT for the reference code 20680, which has similar intra and total time and reflects similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24075

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

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?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25075 Tracking Number P42 Specialty Society Recommended RVU: **3.88**

Global Period: 090 RUC Recommended RVU: **3.88**

CPT Descriptor: Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female undergoes excision of a 2 cm tumor from the anterior aspect of the forearm.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 83% , In the ASC 0%, In the office 17%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 98% , Kept overnight (less than 24 hours) 2% , Admitted (more than 24 hours) 0%

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

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the tumor. Careful dissection is carried down to the tumor taking care to protect any neurovascular structures. The tumor is dissected away from the adjacent tissues and removed. The wound is irrigated. The tourniquet is released and meticulous hemostasis is achieved. The wound is again irrigated. The wound is closed in layers.

escription of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take ecimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider

relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS
Specialty(s):	general surgery; orthopaedic surgery; general & orthopaedic surgical oncology; hand surgery; plastic surgery
CPT Code:	25075

Sample Size:	150	**Resp N:**	58	**Response:**	38.6 %
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**7.00**	13.00	40.00
Survey RVW:	2.50	4.00	**5.25**	6.00	10.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	25075	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11406	010	3.47	**RUC Time**

CPT Descriptor Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 20.6 %

TIME ESTIMATES (Median)	**CPT Code: 25075**	**Key Reference CPT Code: 11406**	**Source of Time RUC Time**
Median Pre-Service Time	34.00	20.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**137.00**	**113.00**	
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	2.25	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.92	1.92
Urgency of medical decision making	1.58	1.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.25	2.08
Physical effort required	1.50	1.58
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.75	1.67
Outcome depends on the skill and judgment of physician	2.17	2.25
Estimated risk of malpractice suit with poor outcome	2.50	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.17	1.75
Intra-Service intensity/complexity	1.92	1.67
Post-Service intensity/complexity	1.50	1.42

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.*

Current code 25075 (Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P42 and P43). During the Harvard study, 12 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 3.88 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.031. This is similar to the IWPUT for the reference code 11406, which is an office-based procedure with a 10-day global period.

SERVICES REPORTED WITH MULTIPLE 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) 25075

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is not available.

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

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

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25071 Tracking Number P43 Specialty Society Recommended RVU: **5.83**

Global Period: 090 RUC Recommended RVU: **5.83**

CPT Descriptor: Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female undergoes excision of a 4 cm tumor from the anterior aspect of the forearm.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 91% , In the ASC 0%, In the office 9%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 96% , Kept overnight (less than 24 hours) 4% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the tumor. Careful dissection is carried down to the tumor taking care to protect any neurovascular structures. The tumor is dissected away from the adjacent tissues and removed. Cultures are taken. The wound is irrigated. The tourniquet is released and meticulous hemostasis is achieved. The wound is again irrigated. The wound is closed in layers.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Tal specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist ι coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider

relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; orthopaedic surgery; general & orthopaedic surgical oncology; hand surgery; plastic surgery				
CPT Code:	25071				
Sample Size:	150	**Resp N:**	58	**Response:** 38.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	9.00	20.00
Survey RVW:	3.00	5.00	**6.00**	7.00	10.50
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	45.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	25071	**Recommended Physician Work RVU: 5.83**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 13.7 %

TIME ESTIMATES (Median)	**CPT Code: 25071**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**178.00**	**181.00**	
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	2.25
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	1.88	1.88

Technical Skill/Physical Effort (Mean)

Technical skill required	1.88	1.88
Physical effort required	1.63	1.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.75	1.75
Outcome depends on the skill and judgment of physician	1.63	1.75
Estimated risk of malpractice suit with poor outcome	2.25	2.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.88	1.88
Intra-Service intensity/complexity	2.00	1.88
Post-Service intensity/complexity	1.50	1.50

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.*

Current code 25075 (Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P42 and P43). During the Harvard study, 12 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 5.83 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.052. This is similar to the IWPUT for the reference code 20680, which has similar intra and total time and reflects similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 25075

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

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?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26115 Tracking Number P49 Specialty Society Recommended RVU: **3.88**

Global Period: 090 RUC Recommended RVU: **3.88**

CPT Descriptor: Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male undergoes excision of a 1 cm tumor from the palmar aspect of the index finger.

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 98% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 2%

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

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A Brunner incision is made over the tumor. Careful dissection of the tumor is carried out. The digital arteries and nerves are identified and carefully protected. The flexor tendon sheath is identified and protected. The tumor is meticulously dissected from the adjacent tissues. The wound is inspected for any residual tumor. The wound is irrigated. The tourniquet is released and meticulous hemostasis is achieved using a bipolar electrocautery. The skin is then closed.

Description of Post-Service Work: Apply soft protective dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report

and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS					
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; hand surgery; plastic surgery					
CPT Code:	26115					
Sample Size:	120	**Resp N:**	64	**Response:** 53.3 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**10.00**	20.00	80.00
Survey RVW:	1.65	3.50	**5.00**	6.00	10.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	26115	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**30.00**		
Immediate Post Service-Time:	**15.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**		
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 17.1 %

TIME ESTIMATES (Median)	**CPT Code: 26115**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	34.00	65.00	
Median Intra-Service Time	30.00	50.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**137.00**	**181.00**	
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	2.11	2.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.89	2.00
Urgency of medical decision making	2.00	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.44	2.67
Physical effort required	2.00	2.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.11	2.33
Outcome depends on the skill and judgment of physician	2.67	2.67
Estimated risk of malpractice suit with poor outcome	2.22	2.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.90	2.10
Intra-Service intensity/complexity	2.30	2.50
Post-Service intensity/complexity	2.00	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.*

Current code 26115 (Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous) will be deleted in 2010 and replaced by two new codes (P49 and P50). During the Harvard study, 14 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. No positioning time and no facility post-work were recorded (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The median RVWs is inconsistent with the intensity of this procedure. The 25th percentile RVW results in an IWPUT of zero. The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 3.88 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. This is the same RVW recommendation for five other small subcutaneous tumor excision codes that have the same intra-time and total time. Along with the recommended time and visit information, this results in an IWPUT of 0.031. This RVW is correctly less than the reference code 20680.

SERVICES REPORTED WITH MULTIPLE 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) 26115

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is not available.

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

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

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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? No

If no, please select another crosswalk and provide a brief rationale. 26115

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:26111 Tracking Number P50 Specialty Society Recommended RVU: **5.34**

Global Period: 090 RUC Recommended RVU: **5.34**

CPT Descriptor: Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male undergoes excision of a 2 cm tumor from the palmar aspect of the index finger.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 86% , In the ASC 0%, In the office 14%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 96% , Kept overnight (less than 24 hours) 2% , Admitted (more than 24 hours) 0%

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

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A Brunner incision is made over the tumor. Careful dissection of the tumor is carried out. The digital arteries and nerves are identified and carefully protected. The flexor tendon sheath is identified and protected. The tumor is meticulously dissected from the adjacent tissues. The wound is inspected for any residual tumor. The wound is irrigated. The tourniquet is released and meticulous hemostasis is achieved using a bipolar electrocautery. The skin is then closed.

Description of Post-Service Work: Apply soft protective dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular

status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; hand surgery; plastic surgery				
CPT Code:	26111				
Sample Size:	120	**Resp N:**	64	**Response:** 53.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**10.00**	20.00	60.00
Survey RVW:	2.10	4.00	**5.50**	7.00	10.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**40.00**	45.00	70.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	26111	**Recommended Physician Work RVU: 5.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 18.7 %

TIME ESTIMATES (Median)	**CPT Code: 26111**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	40.00	50.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
edian Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**173.00**	**181.00**	
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	2.18	2.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	1.91
Urgency of medical decision making	2.09	1.91

Technical Skill/Physical Effort (Mean)

Technical skill required	2.09	2.18
Physical effort required	2.00	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.09	2.09
Outcome depends on the skill and judgment of physician	2.18	2.09
Estimated risk of malpractice suit with poor outcome	2.09	2.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.73	1.73
Intra-Service intensity/complexity	1.91	1.91
Post-Service intensity/complexity	1.73	1.73

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.*

Current code 26115 (Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous) will be deleted in 2010 and replaced by two new codes (P49 and P50). During the Harvard study, 14 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. No positioning time and no facility post-work were recorded (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 5.34 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.047. This RVW is similar to the reference code 20680. The time, visits, intensity and work for both codes are very similar.

SERVICES REPORTED WITH MULTIPLE 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) 26115

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27047 Tracking Number P58 Specialty Society Recommended RVU: **4.86**

Global Period: 090 RUC Recommended RVU: **4.86**

CPT Descriptor: Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male undergoes excision of a 2 cm tumor in his left buttock.

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

Percent of survey respondents who stated they perform the procedure; In the hospital 89% , In the ASC 0%, In the office 11%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 97% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 0%

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

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery and hemostasis is controlled. The tumor is excised along with proper margin of tissue. Hemostasis is secured with electrocautery and sutures where needed. Small lymphatic channels are ligated. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain

medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Reconc medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Disc progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	27047					
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**6.00**	8.00	20.00
Survey RVW:	2.00	4.00	**5.00**	6.00	15.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	27047	**Recommended Physician Work RVU: 4.86**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**18.00**	**1.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
46040	090	5.26	RUC Time

CPT Descriptor Incision and drainage of ischiorectal and/or perirectal abscess (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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 22.8 %

TIME ESTIMATES (Median)

	CPT Code: 27047	Key Reference CPT Code: 46040	Source of Time RUC Time
Median Pre-Service Time	42.00	60.00	
Median Intra-Service Time	40.00	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	39.0	55.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**160.00**	**184.00**	
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	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.63	2.88
Urgency of medical decision making	2.88	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	2.88
Physical effort required	3.25	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	3.00
Outcome depends on the skill and judgment of physician	3.88	3.50
Estimated risk of malpractice suit with poor outcome	3.13	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.75	2.63
Intra-Service intensity/complexity	2.63	2.63
Post-Service intensity/complexity	2.38	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.*

Current code 27047 (Excision, tumor, pelvis and hip area; subcutaneous tissue) will be deleted in 2010 and replaced by two new codes (P58 and P59). During the Harvard study, 8 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 17 minutes to account for lateral positioning.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 4.86 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.040. This is similar to the IWPUT for the reference code 46040, which has less intra-time, but more total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27047

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%

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

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27043 Tracking Number P59 Specialty Society Recommended RVU: **6.80**

Global Period: 090 RUC Recommended RVU: **6.80**

CPT Descriptor: Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old female undergoes excision of a 5 cm tumor in her lateral buttock.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 86% , Kept overnight (less than 24 hours) 14% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 60%

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

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

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

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery to expose the lesion and hemostasis is controlled. The tumor is excised along with proper margin of tissue. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Wri brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare

professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	27043					
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**5.00**	6.00	24.00
Survey RVW:	4.00	5.95	**7.00**	8.55	15.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	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**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

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

CPT Code:	27043	**Recommended Physician Work RVU: 6.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38525	090	6.35	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep axillary node(s)

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

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

CPT Descriptor 1

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

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 22.8 %

TIME ESTIMATES (Median)	CPT Code: 27043	Key Reference CPT Code: 38525	Source of Time RUC Time
Median Pre-Service Time	68.00	45.00	
Median Intra-Service Time	60.00	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	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**206.00**	**178.00**	
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	2.63	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.63	2.75
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.63	3.13
Physical effort required	3.25	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	3.00
Outcome depends on the skill and judgment of physician	3.38	3.38
Estimated risk of malpractice suit with poor outcome	3.13	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.13
Intra-Service intensity/complexity	3.38	3.00
Post-Service intensity/complexity	2.88	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.*

Current code 27047 (Excision, tumor, pelvis and hip area; subcutaneous tissue) will be deleted in 2010 and replaced by two new codes (P58 and P59). During the Harvard study, 8 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for lateral positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 6.80 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.051. This is similar to the IWPUT for the reference code 38525, which has less intra-time and less total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27047

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

pecialty 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?

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27327 Tracking Number P68 Specialty Society Recommended RVU: **3.88**

Global Period: 090 RUC Recommended RVU: **3.88**

CPT Descriptor: Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old female undergoes excision of a 2 cm tumor in her lateral thigh.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 98% , Kept overnight (less than 24 hours) 2% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with patient positioning in a supine and slightly lateral position, with the leg bumped up 30 degrees and stabilized. Indicate areas of skin to be prepped and mark surgical incisions. Prep and drape leg. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 4cm incision is made in the skin and subcutaneous tissue over the tumor on the lateral thigh. Careful dissection is performed around the subcutaneous mass. The 2 cm mass is removed from the surrounding tissue. The tumor is handed off of the field. Hemostasis is obtained. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are

completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiv as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery					
CPT Code:	27327					
Sample Size:	120	**Resp N:**	42	**Response:** 35.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		1.00	4.00	**6.00**	15.00	50.00
Survey RVW:		2.00	4.00	**6.00**	7.00	12.00
Pre-Service Evaluation Time:				**30.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		15.00	25.00	**30.00**	45.00	65.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	27327	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**8.00**	**1.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**30.00**		
Immediate Post Service-Time:	**20.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**		
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
11622	010	2.36	**RUC Time**

CPT Descriptor Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)	**CPT Code: 27327**	**Key Reference CPT Code: 11622**	**Source of Time RUC Time**
Median Pre-Service Time	32.00	15.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	20.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**140.00**	**87.00**	
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	2.14	2.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.29	2.43
Urgency of medical decision making	2.71	2.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.43	2.29
Physical effort required	2.29	2.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.57	2.57
Outcome depends on the skill and judgment of physician	3.14	3.00
Estimated risk of malpractice suit with poor outcome	3.14	2.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.14	1.86
Intra-Service intensity/complexity	2.29	2.00
Post-Service intensity/complexity	2.14	1.86

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.*

Current code 27327 (Excision, tumor, thigh or knee area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P68 and P69). During the Harvard study, 10 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 7 minutes. After induction of anesthesia in supine position, patient will be adjusted slightly lateral, with the leg bumped up 30 degrees and stabilized and padding of opposite extremity.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 3.88 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. This is less than the current RVW for 27327. Along with the recommended time and visit information, this results in an IWPUT of 0.028. This is less than the IWPUT for the reference code 11622, which has less intra-time, one office visit and has a 10-day global period.

SERVICES REPORTED WITH MULTIPLE 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) 27327

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27337 Tracking Number P69 Specialty Society Recommended RVU: **5.83**

Global Period: 090 RUC Recommended RVU: **5.83**

CPT Descriptor: Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female undergoes excision of a 5 cm tumor in her medial anterior thigh.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 74% , Kept overnight (less than 24 hours) 24% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 91%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning in a supine position, with the leg bumped up 30 degrees and stabilized. Indicate areas of skin to be prepped and mark surgical incisions. Prep and drape leg. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A sterile tourniquet is applied and inflated. Under anesthesia, a 7 cm incision is made in the skin and subcutaneous tissue over the anteromedial thigh. Medial and lateral flaps are raised and careful dissection is performed around the 5 cm tumor. The tumor is removed. Hemostasis is obtained. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. Assess neurovascular statu Wound care and close observation are important to avoid or promptly treat compartment syndrome. After patient . awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain

medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures and drain; and discuss pathology report when available. Order and eview periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery				
CPT Code:	27337				
Sample Size:	120	**Resp N:**	42	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**8.00**	15.00	50.00
Survey RVW:	3.50	6.00	**8.00**	10.00	23.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	40.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	27337	**Recommended Physician Work RVU: 5.83**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)	**CPT Code: 27337**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	58.00	65.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**181.00**	**181.00**	
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	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.88
Urgency of medical decision making	3.00	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	2.88	3.13
Physical effort required	2.75	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.25
Outcome depends on the skill and judgment of physician	3.38	3.50
Estimated risk of malpractice suit with poor outcome	3.25	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	3.13
Intra-Service intensity/complexity	2.75	3.00
Post-Service intensity/complexity	2.88	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.*

Current code 27327 (Excision, tumor, thigh or knee area; subcutaneous) will be deleted in 2010 and replaced by two new codes (P68 and P69). During the Harvard study, 10 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 7 minutes. After induction of anesthesia in supine position, patient will be adjusted slightly lateral, with the leg bumped up 30 degrees and stabilized and padding of opposite extremity.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 5.83 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.051. This is the same as the IWPUT for the reference code 20680. Pre, intra, and post work for both procedures is very similar.

SERVICES REPORTED WITH MULTIPLE 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) 27327

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specia.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27618 Tracking Number P77 Specialty Society Recommended RVU: **3.88**

Global Period: 090 RUC Recommended RVU: **3.88**

CPT Descriptor: Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old undergoes excision of 2 cm tumor in her left lateral lower leg.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 88% , In the ASC 0%, In the office 12%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 95% , Kept overnight (less than 24 hours) 5% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with patient positioning in a supine and slightly lateral position, with the leg bumped up 30 degrees and stabilized. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 4cm incision is made in the skin and subcutaneous tissue over the tumor on the leg. Careful dissection around the tumor is performed. The tumor is excised en bloc. The wound is inspected and irrigated. The tourniquet is deflated and any bleeders are cauterized. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain

medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and revi periodic lab and/or imaging, as necessary. Reconcile medication(s). Revise treatment plan(s) and communicate v patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes fo medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	27618				
Sample Size:	150	**Resp N:**	49	**Response:** 32.6 %	
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:	1.65	4.00	**5.00**	8.00	10.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	10.00	30.00	**30.00**	30.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	27618	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11406	010	3.47	**RUC Time**

CPT Descriptor Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.4 %

TIME ESTIMATES (Median)	**CPT Code: 27618**	**Key Reference CPT Code: 11406**	**Source of Time RUC Time**
Median Pre-Service Time	34.00	20.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**137.00**	**113.00**	
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	2.40	1.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.10
Urgency of medical decision making	2.30	2.30

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.50
Physical effort required	2.50	2.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.30
Outcome depends on the skill and judgment of physician	2.70	2.70
Estimated risk of malpractice suit with poor outcome	2.90	2.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.30	2.10
Intra-Service intensity/complexity	2.20	2.10
Post-Service intensity/complexity	1.90	1.80

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.*

Current code 27618 (Excision, tumor, leg or ankle area; subcutaneous tissue) will be deleted in 2010 and replaced by two new codes (P77 and P78). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, and podiatry were not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes - move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, patient is adjusted slightly later, with the leg bumped up 30 degrees and stabilized with padding of opposite extremity. Tourniquet is applied.
- Scrub/Dress/Wait: Add 5 minutes - moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 3.88 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.031. This is similar to the IWPUT for the reference code 11406, which is an office-based 10-day global procedure with one office visit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27618

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
pecialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27632 Tracking Number P78 Specialty Society Recommended RVU: **5.83**

Global Period: 090 RUC Recommended RVU: **5.83**

CPT Descriptor: Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male undergoes excision of a 3.5 cm tumor in the medial calf.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 94% , In the ASC 0%, In the office 6%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 93% , Kept overnight (less than 24 hours) 7% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 67%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Assist with patient positioning in a supine and slightly lateral position, with the leg bumped up 30 degrees and stabilized. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 6 cm incision is made in the skin and subcutaneous tissue over the tumor on the leg. Careful dissection around the tumor is performed. The tumor is excised en bloc. The wound is inspected and irrigated. The tourniquet is deflated and any bleeders are cauterized. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings and splint. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's famil Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and appropriate use of crutches or walker. Reconcile

medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one to two days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures and drain; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	27632				
Sample Size:	150	**Resp N:**	49	**Response:**	32.6 %
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	5.00	50.00
Survey RVW:	2.36	6.00	**7.00**	9.00	12.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**11.00**		
Intra-Service Time:	15.00	30.00	**45.00**	45.00	105.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	27632	**Recommended Physician Work RVU: 5.83**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
20680	090	5.90	**RUC Time**

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)	**CPT Code: 27632**	**Key Reference CPT Code: 20680**	**Source of Time RUC Time**
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**183.00**	**181.00**	
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	2.57	1.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	2.00
Urgency of medical decision making	2.29	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.00	1.86
Physical effort required	1.86	1.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	1.71
Outcome depends on the skill and judgment of physician	2.00	1.71
Estimated risk of malpractice suit with poor outcome	2.29	1.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.14	1.86
Intra-Service intensity/complexity	2.00	1.71
Post-Service intensity/complexity	1.57	1.25

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.*

Current code 27618 (Excision, tumor, leg or ankle area; subcutaneous tissue) will be deleted in 2010 and replaced by two new codes (P77 and P78). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, and podiatry were not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, patient is adjusted slightly lateral, with the leg bumped up 30 degrees and stabilized with padding of opposite extremity. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 5.83 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.050. This is similar to the IWPUT for the reference code 20680, a procedure that has essentially the same total work as the survey 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) 27618

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

stimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

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?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28043 Tracking Number P86 Specialty Society Recommended RVU: **3.88**

Global Period: 090 RUC Recommended RVU: **3.88**

CPT Descriptor: Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female undergoes excision of a 1.2 cm fibrous tumor in the subcutaneous tissue of the right foot.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 75% , In the ASC 0%, In the office 25%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made on the plantar aspect of the first intermetatarsal space. Dissection is carried out to reveal the fibrous lesion. The tumor is dissected from surrounding tissue, and all bleeders are cauterized. The lesion is delivered from the wound. The wound is irrigated, inspected, and closed in layers with interrupted sutures. The skin is coapted with a running mattress of nylon. The tourniquet is deflated, and normal capillary return is seen in the toes.

Description of Post-Service Work: Apply sterile dressing and splint/shoe. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications

and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	28043				
Sample Size:	120	**Resp N:** 48	**Response:** 40.0 %		
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	12.00	50.00
Survey RVW:	1.65	2.24	**4.00**	6.00	10.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	10.00	20.00	**30.00**	31.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	28043	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**6.00**	**1.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11422	010	1.65	**RUC Time**

CPT Descriptor Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 31.2 %

TIME ESTIMATES (Median)	CPT Code: 28043	Key Reference CPT Code: 11422	Source of Time RUC Time
Median Pre-Service Time	30.00	10.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	20.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**138.00**	**56.00**	
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	2.55	2.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.27	2.27
Urgency of medical decision making	2.09	2.09

Technical Skill/Physical Effort (Mean)

Technical skill required	2.18	2.09
Physical effort required	2.18	2.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.09
Outcome depends on the skill and judgment of physician	2.73	2.55
Estimated risk of malpractice suit with poor outcome	2.55	2.55

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.73	1.82
Intra-Service intensity/complexity	1.82	1.82
Post-Service intensity/complexity	1.82	1.91

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.*

Current code 28043 (Excision, tumor, foot; subcutaneous tissue) will be deleted in 2010 and replaced by two new codes (P86 and P87). During the Harvard study, 10 orthopaedic surgeons were surveyed. Podiatry, the primary and significant provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: No change. The 5 minutes allocated for moderate sedation by an anesthesiologist is replaced by 5 minutes for the surgeon to perform a regional block.
- Positioning: Add 5 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 3.88 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.028. This is less than the IWPUT for the reference code 11422, a procedure that is office based, has one post-op visit and has a 10-day global period.

SERVICES REPORTED WITH MULTIPLE 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) 28043

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 28043

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:28039 Tracking Number P87 Specialty Society Recommended RVU: **5.34**

Global Period: 090 RUC Recommended RVU: **5.34**

CPT Descriptor: Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female undergoes excision of a 2.0 cm fibrous tumor in the subcutaneous tissue of the right foot.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 85% , In the ASC 0%, In the office 15%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made on the plantar aspect of the first intermetatarsal space. Dissection is carried out to reveal a fibrous lesion. The lesion is dissected from surrounding tissue, and all bleeders are cauterized. The lesion is delivered from the wound. The wound site is irrigated and inspected. The wound is closed in layers with simple interrupted sutures and the skin is coapted with a running mattress of nylon. The tourniquet is deflated, and normal capillary return is seen in the toes.

Description of Post-Service Work: Apply sterile dressing and splint/shoe. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications

and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM					
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry					
CPT Code:	28039					
Sample Size:	120	**Resp N:**	48	**Response:** 40.0 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**5.00**	8.00	50.00	
Survey RVW:	2.00	3.90	**6.00**	8.33	12.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	20.00	30.00	**45.00**	45.00	60.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	28039	**Recommended Physician Work RVU: 5.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**6.00**	**1.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		
Immediate Post Service-Time:	**20.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**		
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 16.6 %

TIME ESTIMATES (Median)	CPT Code: 28039	Key Reference CPT Code: 28289	Source of Time RUC Time
Median Pre-Service Time	30.00	30.00	
Median Intra-Service Time	45.00	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	39.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**153.00**	**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	2.75	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.88
Urgency of medical decision making	2.63	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	2.63	2.88
Physical effort required	2.63	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.38	2.50
Outcome depends on the skill and judgment of physician	3.13	3.38
Estimated risk of malpractice suit with poor outcome	2.63	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.38	2.50
Intra-Service intensity/complexity	2.50	2.75
Post-Service intensity/complexity	2.00	2.38

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.*

Current code 28043 (Excision, tumor, foot; subcutaneous tissue) will be deleted in 2010 and replaced by two new codes (P86 and P87). During the Harvard study, 10 orthopaedic surgeons were surveyed. Podiatry, the primary and significant provider of this service, was not involved. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: No change. The 5 minutes allocated for moderate sedation by an anesthesiologist is replaced by 5 minutes for the surgeon to perform a regional block.
- Positioning: Add 5 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends an RVW that is the same as P50 to place this subcutaneous code in correct rank order with the rest of the family of subcutaneous codes. Additionally, this value has been *adjusted* (decreased) to 5.34 RVWs to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.054. This is similar to the IWPUT for the reference code 28289. The RVW is less than the reference code, accounting for less office visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28043

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 28525

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:21556 Tracking Number P9 Specialty Society Recommended RVU: **7.53**

Global Period: 090 RUC Recommended RVU: **7.53**

CPT Descriptor: Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male undergoes excision of a 3 cm tumor deep in the posterior-lateral para-spinal region of the neck behind the sternocleidomastoid.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 64% , Kept overnight (less than 24 hours) 32% , Admitted (more than 24 hours) 4%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 78%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning and adjusting the OR table and anesthesia lines so that the operative site is assessable. Assess position of the extremities and head, adjust as needed. 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 longitudinal incision is made over the posterior-cervical triangle. The platysma is identified and split with the major portion retracted anteriorly. The posterior portion of the sternocleidomastoid and the interval between the sternocleidomastoid and the anterior trapezius is identified. Within that interval, great care is necessary to avoid injuring the spinal accessory nerve root which innervates the muscles. Dissection is carried deep between those two muscles. Sensory branches of the cervical nerves to the skin cross the posterior portion of the sternocleidomastoid muscle and are protected. The branch of the transverse cervical artery in the inferior portion of the wound has to be ligated and incised. The carotid sheath and jugular vein can be palpated anteriorly in the incision and are carefully retracted out of the field. Several perforating vessels off the jugular vein are also ligated and incised. As the interval is further explored, the mass is palpable deep within the wound. At this point, in the inferior portion of the incision, the omo-hyoid muscle is identified posteriorly, the levator scapula and the middle scalene muscles are identified in the proximal wound, and the anterior scalene identified in the proximal anterior wound.

The mass itself is sitting directly between them and has spread them apart. The mass is then identified and appears to be consistent with the MRI which showed homogenous mass consistent with a lipoma. Since it is a lipoma, a marginal resection will be performed. The mass is peeled off the anterior scalene muscle and the omo-hyoid and gradually retracted off the anterior portion of the wound. This is freed up from the back of the carotid sheath and the jugular ve

Several small feeding vessels into the lipoma are ligated and incised. Inferior in the wound, the brachial plexus can palpated deep in the interval between the anterior and middle scalene. It is directly underneath and adherent to the underside of the lipoma. Very carefully the nerve roots are retracted and the lipoma is carefully dissected off the major trunks of the brachial plexus in the bottom of the wound. Next to the brachial plexus, the take off of the subclavian artery and vein can be seen. Several small perforating branches can be seen there and these are retracted out of the way as well as the suprascapular artery coming off the base of the thyro-cervical trunk. Once that area is identified, the rest of the lipoma is gently dissected off the brachial plexus and is removed in block. Since it is lipoma, frozen sections are not performed on the margins. The mass is handed off the field. The gloves and instruments are changed and the wound is copiously irrigated. Hemostasis is obtained. The top of the brachial plexus is inspected to make sure that there is no damage to any of the major nerve trunks. The spinal accessory nerve proximally in the wound can be seen as it goes underneath the sternocleidomastoid and trapezius and that is also inspected to make sure there is no injury. A drain is placed with great care to make sure it's not on either the subclavian vessels or carotid sheath. This is brought out posteriorly. The posterior triangle also has several lymph nodes in the area and the lymph chain here had to be carefully protected since in a lipoma there is no need to remove the lymph nodes. The muscles are allowed to retract back into their original location. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied to the neck. A cervical collar is applied to help control head rotation. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including a recheck of hematocrit. The patient will be put on an oxygen monitor since with neck surgery any hematoma could put pressure on the trachea. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Exami patient, assessing hemodynamic status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS				
Specialty(s):	general surgery; otolaryngology				
CPT Code:	21556				
Sample Size:	75	**Resp N:**	30	**Response:** 40.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**2.00**	5.00	10.00
Survey RVW:	5.00	7.00	**7.75**	11.10	18.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	50.00	**60.00**	75.00	120.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	21556	**Recommended Physician Work RVU: 7.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38510	010	6.69	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep cervical node(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 53.3 %

TIME ESTIMATES (Median)	CPT Code: 21556	Key Reference CPT Code: 38510	Source of Time RUC Time
Median Pre-Service Time	68.00	45.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	25.00	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	62.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**234.00**	**152.00**	
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	2.93	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.47
Urgency of medical decision making	2.73	2.60

Technical Skill/Physical Effort (Mean)

Technical skill required	3.27	3.07
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.73	2.73
Outcome depends on the skill and judgment of physician	3.33	3.20
Estimated risk of malpractice suit with poor outcome	2.87	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.71	2.79
Intra-Service intensity/complexity	2.86	3.07
Post-Service intensity/complexity	2.07	2.07

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21556 (Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular) will be deleted in 2010 and replaced by two new codes (P9 and P10). During the Harvard study, 10 general surgeons were surveyed. Otolaryngology was not involved. Pre and post times were predicted. No positioning work was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 7.53 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.045. This RVW is greater than the reference code 38510 which has a 10-day global period, one post-op office visit, and less intra-op time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 21556

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

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:21554 Tracking Number P10 Specialty Society Recommended RVU: **12.47**

Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male undergoes excision of a 9 cm tumor deep in the posterior-lateral para-spinal region of the neck behind the sternocleidomastoid.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 11% , Kept overnight (less than 24 hours) 61% , Admitted (more than 24 hours) 29%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning and adjusting the OR table and anesthesia lines so that the operative site is assessable. Assess position of the extremities and head, adjust as needed. 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 longitudinal incision is made over the posterior-cervical triangle. The platysma is identified and split with the major portion retracted anteriorly. The posterior portion of the sternocleidomastoid and the interval between the sternocleidomastoid and the anterior trapezius is identified. Within that interval, great care is necessary to avoid injuring the spinal accessory nerve root which innervates the muscles. Dissection is carried deep between those two muscles. Sensory branches of the cervical nerves to the skin cross the posterior portion of the sternocleidomastoid muscle and are protected. The branch of the transverse cervical artery the inferior portion of the wound has to be ligated and incised. The carotid sheath and jugular vein can be palpated anteriorly in the incision and are carefully retracted out of the field. Several perforating vessels off the jugular vein are also ligated and incised. As the interval is further explored, the mass is palpable deep within the wound. At this point, in the inferior portion of the incision, the omo-hyoid muscle is identified posteriorly, the levator scapula and the middle scalene muscles are identified in the proximal wound, and the anterior scalene identified in the proximal anterior wound.

The mass itself is sitting directly between them and has spread them apart. The mass is then identified and appears to be consistent with the MRI which showed homogenous mass consistent with a lipoma. Since it is a lipoma, a marginal resection will be performed. The mass is peeled off the anterior scalene muscle and the omo-hyoid and gradually retracted off the anterior portion of the wound. This is freed up from the back of the carotid sheath and the jugular vein. Several small feeding vessels into the lipoma are ligated and incised. Inferior in the wound, the brachial plexus can be palpated deep in the interval between the anterior and middle scalene. It is directly underneath and adherent to the underside of the lipoma. Very carefully the nerve roots are retracted and the lipoma is carefully dissected off the major trunks of the brachial plexus in the bottom of the wound. Next to the brachial plexus, the take off of the subclavian artery and vein can be seen. Several small perforating branches can be seen there and these are retracted out of the way as well as the suprascapular artery coming off the base of the thyro-cervical trunk. Once that area is identified, the rest of the lipoma is gently dissected off the brachial plexus and is removed in block. Since it is lipoma, frozen sections are not performed on the margins. The mass is handed off the field. The gloves and instruments are changed and the wound is copiously irrigated. Hemostasis is obtained. The top of the brachial plexus is inspected to make sure that there is no damage to any of the major nerve trunks. The spinal accessory nerve proximally in the wound can be seen as it goes underneath the sternocleidomastoid and trapezius and that is also inspected to make sure there is no injury. A drain is placed with great care to make sure it's not on either the subclavian vessels or carotid sheath. This is brought out posteriorly. The posterior triangle also has several lymph nodes in the area and the lymph chain here had to be carefully protected since in a lipoma there is no need to remove the lymph nodes. The muscles are allowed to retract back into their original location. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied to the neck. A cervical collar is applied to help control head rotation. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including a recheck of hematocrit. The patient will be put on an oxygen monitor since with neck surgery any hematoma could put pressure on the trachea. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing hemodynamic status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drains when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS		
Specialty(s):	general surgery; otolaryngology		
CPT Code:	21554		
Sample Size:	75	**Resp N:** 30	**Response:** 40.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	15.00
Survey RVW:	7.78	11.00	**12.84**	14.00	21.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	68.00	**90.00**	100.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21554	**Recommended Physician Work RVU: 12.47**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38700	090	12.68	RUC Time

CPT Descriptor Suprahyoid lymphadenectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)	CPT Code: 21554	Key Reference CPT Code: 38700	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
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	20.0	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	**320.00**	**300.00**	
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	3.80	3.50
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	2.70	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.90	3.30
Physical effort required	3.60	3.10

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.50
Outcome depends on the skill and judgment of physician	4.30	3.80
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.40	3.60
Intra-Service intensity/complexity	3.80	3.40
Post-Service intensity/complexity	2.50	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21556 (Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular) will be deleted in 2010 and replaced by two new codes (P9 and P10). During the Harvard study, 10 general surgeons were surveyed. Otolaryngology was not involved. Pre and post times were predicted. No positioning work was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change.
- Positioning: Add 17 minutes for prone positioning.
- Scrub/Dress/Wait: No change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 12.47 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.066. This RVW is similar to the reference code 38700 which requires similar intra-op time and work and similar total work.

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.

FREQUENCY INFORMATION

'ow was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted ode is reviewed) 21556

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22900 Tracking Number P21 Specialty Society Recommended RVU: **8.21**

Global Period: 090 RUC Recommended RVU: **8.21**

CPT Descriptor: Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male undergoes excision of a 4 cm lipoma of the external oblique muscle.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 39% , Kept overnight (less than 24 hours) 39% , Admitted (more than 24 hours) 21%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 85%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Patient is placed in supine position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery. The external oblique muscle is exposed around the tumor. The tumor is excised along with surrounding muscle using electrocautery and dissection. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. Devitalized muscle is debrided. Where possible, the muscle fascial defect is approximated. A Penrose drain is placed in the cavitary defect. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review

medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Disc. aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	22900				
Sample Size: 100	**Resp N:** 34	**Response:** 34.0 %			
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:	5.00	7.89	**9.00**	11.50	20.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	22900	**Recommended Physician Work RVU: 8.21**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
49505	090	7.88	RUC Time

CPT Descriptor Repair initial inguinal hernia, age 5 years or older; reducible

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 26.4 %

TIME ESTIMATES (Median)

	CPT Code: 22900	Key Reference CPT Code: 49505	Source of Time RUC Time
Median Pre-Service Time	51.00	50.00	
Median Intra-Service Time	60.00	70.00	
Median Immediate Post-service Time	20.00	20.00	
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	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**244.00**	**198.00**	
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	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.44
Urgency of medical decision making	2.89	2.56
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.22	3.00
Physical effort required	2.89	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.78	2.44
Outcome depends on the skill and judgment of physician	3.22	2.89
Estimated risk of malpractice suit with poor outcome	2.78	2.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.89	2.67
Intra-Service intensity/complexity	2.89	2.78
Post-Service intensity/complexity	2.56	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 22900 (Excision, abdominal wall tumor, subfascial (eg, desmoid)) will be deleted in 2010 and replaced by two new codes (P21 and P22). During the Harvard study, 14 general surgeons were surveyed. The data that included hospital work was truncated by the RUC based on Medicare frequency. The typical patient is not Medicare-age and these patients will typically require a drain and will stay overnight in the hospital for monitoring. Further, without requiring a RUC survey in 1995 during the first 5-year-review, the code was reduced based on a comment letter.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with no changes

Recommendation: The consensus committee recommends an RVW that is midway between the survey 25th percentile and median to place this code in correct rank order with the rest of the family of subfacial codes. Additionally, this value has been *adjusted* (decreased) to 8.21 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.050. The RVW is greater than the reference code 49505, which has less post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22900

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22901 Tracking Number P22 Specialty Society Recommended RVU: **11.65**

Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female undergoes excision of a 9 cm lipoma of the external oblique muscle.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 6% , Kept overnight (less than 24 hours) 71% , Admitted (more than 24 hours) 24%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 79%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of x-ray, CT, MRI, MRA. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation. Verify that all required instruments and supplies are available. Patient is placed in supine position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. The tumor is excised along with surrounding muscle using electrocautery and dissection. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs and /or peritoneum is carried out. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated Devitalized muscle is debrided. Where possible, the muscle fascial defect is approximated. A Penrose drain is placed the cavitary defect. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write

brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	22901				
Sample Size: 100	**Resp N:** 34	**Response:** 34.0 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	10.00
Survey RVW:	8.00	11.31	**12.00**	14.75	22.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	75.00	**90.00**	98.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	22901	**Recommended Physician Work RVU: 11.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
49560	090	11.84	**RUC Time**

CPT Descriptor Repair initial incisional or ventral hernia; reducible

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 23.5 %

TIME ESTIMATES (Median)	**CPT Code: 22901**	**Key Reference CPT Code: 49560**	**Source of Time RUC Time**
Median Pre-Service Time	51.00	45.00	
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	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
ledian Office Visit Time	55.0	39.00	
rolonged Services Time	0.0	0.00	
Median Total Time	**284.00**	**223.00**	
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	2.63
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	2.88	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.75	3.50
Physical effort required	3.38	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.38	3.38
Outcome depends on the skill and judgment of physician	3.88	3.50
Estimated risk of malpractice suit with poor outcome	3.75	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.00
Intra-Service intensity/complexity	3.63	3.25
Post-Service intensity/complexity	2.88	2.63

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 22900 (Excision, abdominal wall tumor, subfascial (eg, desmoid)) will be deleted in 2010 and replaced by two new codes (P21 and P22). During the Harvard study, 14 general surgeons were surveyed. The data that included hospital work was truncated by the RUC based on Medicare frequency. The typical patient is not Medicare-age and these patients will typically require a drain and will stay overnight in the hospital for monitoring. Further, without requiring a RUC survey in 1995 during the first 5-year-review, the code was reduced based on a comment letter.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

- Pre-Time: With respect to the pre-service time, we recommend package 3 with no changes.

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 11.65 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.069. The RVW is similar to the reference code 49560, which has less post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

low was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22900

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23076 Tracking Number P27 Specialty Society Recommended RVU: **7.28**

Global Period: 090 RUC Recommended RVU: **7.28**

CPT Descriptor: Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old female undergoes excision of a 3.5 cm lipoma deep within the subscapularis muscle.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 60% , Kept overnight (less than 24 hours) 37% , Admitted (more than 24 hours) 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with lateral beach chair positioning, exposing the shoulder and stabilizing the patient's torso. 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 anterior shoulder following the delto-pectoral groove. The subcutaneous tissue is incised and the cephalic vein is identified and dissected up to the coracoid process. The pectoralis major tendon inserting in the humerus is retracted. A retractor is placed under the deltoid to expose the proximal humerus. The pectoral fascia is incised and retracted medially and laterally. The shoulder is then externally rotated and dissection is performed on the inferior medial portion of the subscapularis muscle so a retractor could be gently inserted to protect the axillary nerve where it comes across the inferior portion of the wound. The shoulder is externally rotated the subscapularis insertion on the anterior shoulder is identified and a retractor is used to retract the conjoined tendon medially. The mass is able to be palpated just under the conjoined tendon both medial to it and lateral to it. With retractors medially holding the conjoined tendon, a horizontal split is made in the subscapularis muscle. This dissection is carried down until the tumor is encountered. The conjoined tendon is protected. Dissection is performed on both sides of the tendon. The musculocutaneus nerve is identified and protected. With the split in the subscapularis muscle accomplished, the lipoma is dissected out in one piece and handed out of the operative field. Retractors are used within the subscapularis to hold both the superior and inferior portions of it in place. The thoracoacromial arch is

avoided during the surgery to minimize bleeding in the superior portion of the wound. The wound is irrigated. Instruments and gloves are then changed. The cavity in the subscapularis is carefully inspected and there is found to be no residual tumor. A deep drain is placed within the subscapularis and brought out the anterior skin flap. The defect in the sub-scapularis is closed with an interrupted suture. Since the conjoined tendon is left in place. The musculocutaneu nerve entering medial side of the biceps is inspected and found to be intact. The retractors protecting the inferior porti of the subscapularis are removed. The retractor holding back the cephalic vein is also removed. The wound is closed in layers.

Description of Post-Service Work: Apply sterile dressings and shoulder immobilizer. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	23076				
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**5.00**	8.00	25.00
Survey RVW:	6.00	7.50	**8.50**	9.75	20.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	23076	**Recommended Physician Work RVU: 7.28**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
ffice time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
13132	010	6.48	**RUC Time**

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)	CPT Code: 23076	Key Reference CPT Code: 13132	Source of Time RUC Time
Median Pre-Service Time	60.00	30.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	62.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**221.00**	**136.00**	
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	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	2.88
Urgency of medical decision making	3.38	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	3.25
Physical effort required	3.38	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.25	3.13
Outcome depends on the skill and judgment of physician	3.25	3.25
Estimated risk of malpractice suit with poor outcome	3.38	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.63
Intra-Service intensity/complexity	2.88	2.75
Post-Service intensity/complexity	2.88	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 23076 (Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular) will be deleted in 2010 and replaced by two new codes (P27 and P28). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. The current survey, which includes general surgeons results in different time and visit data.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder and stabilize the patient's torso.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 7.28 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.046. This RVW is slightly greater than the 10-day global reference code, accounting for additional intra-op time and post-op work and is less than the current RVW for 23076.

SERVICES REPORTED WITH MULTIPLE 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) 23076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

)o 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:23073 Tracking Number P28 Specialty Society Recommended RVU: **10.93**

Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old female undergoes excision of a 7.5 cm lipoma deep within the subscapularis muscle.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 6% , Kept overnight (less than 24 hours) 69% , Admitted (more than 24 hours) 26%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with lateral beach chair positioning, exposing the shoulder and stabilizing the patient's torso. 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 anterior shoulder following the delto-pectoral groove. The subcutaneous tissue is incised and the cephalic vein is identified and dissected up to the coracoid process. The pectoralis major tendon inserting in the humerus is retracted. A retractor is placed under the deltoid to expose the proximal humerus. The pectoral fascia is incised and retracted medially and laterally. The shoulder is then externally rotated and dissection is performed on the inferior medial portion of the subscapularis muscle so a retractor could be gently inserted to protect the axillary nerve where it comes across the inferior portion of the wound. The shoulder is externally rotated the subscapularis insertion on the anterior shoulder is identified and a retractor is used to retract ' conjoined tendon medially. The mass is able to be palpated just under the conjoined tendon both medial to it and late to it. With retractors medially holding the conjoined tendon, a horizontal split is made in the subscapularis muscle. This dissection is carried down until the tumor is encountered. The conjoined tendon is protected. Dissection is performed on both sides of the tendon. The musculocutaneus nerve is identified and protected. With the split in the subscapularis muscle accomplished, the lipoma is dissected out in one piece and handed out of the operative field. Retractors are used

within the subscapularis to hold both the superior and inferior portions of it in place. The thoracoacromial arch is avoided during the surgery to minimize bleeding in the superior portion of the wound. The wound is irrigated. Instruments and gloves are then changed. The cavity in the subscapularis is carefully inspected and there is found to be no residual tumor. A deep drain is placed within the subscapularis and brought out the anterior skin flap. The defect in he sub-scapularis is closed with an interrupted suture. Since the conjoined tendon is left in place. The musculocutaneus nerve entering medial side of the biceps is inspected and found to be intact. The retractors protecting the inferior portion of the subscapularis are removed. The retractor holding back the cephalic vein is also removed. The wound is closed in layers.

Description of Post-Service Work: Apply soft dressings and shoulder immobilizer. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order ccupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	23073				
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**4.00**	8.00	25.00
Survey RVW:	8.50	10.00	**12.50**	15.00	22.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	45.00	60.00	**75.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	23073	**Recommended Physician Work RVU: 10.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
29828	090	13.00	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; biceps tenodesis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	CPT Code: 23073	Key Reference CPT Code: 29828	Source of Time RUC Time
Median Pre-Service Time	60.00	70.00	
Median Intra-Service Time	75.00	75.00	
Median Immediate Post-service Time	30.00	20.00	
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	62.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**285.00**	**262.00**	
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	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.00
Urgency of medical decision making	3.00	2.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	2.67	2.67

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	3.50	3.33
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	3.33	2.67
Intra-Service intensity/complexity	3.00	3.17
Post-Service intensity/complexity	2.83	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 23076 (Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular) will be deleted in 2010 and replaced by two new codes (P27 and P28). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. The current survey, which includes general surgeons results in different time and visit data.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder and stabilize the patient's torso.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends an RVW that is midway between the survey 25th percentile and median to place this code in correct rank order with the rest of the family of subfacial codes. Additionally, this value has been *adjusted* (decreased) to 10.93 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.061. This is less than the IWPUT for the reference code 29828, which has the same intra-operative time and less total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 23076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24076 Tracking Number P36 Specialty Society Recommended RVU: **7.28**

Global Period: 090 RUC Recommended RVU: **7.28**

CPT Descriptor: Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male undergoes excision of a 3 cm myxoma from between the humerus and triceps.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 67% , Kept overnight (less than 24 hours) 29% , Admitted (more than 24 hours) 5%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A posterior incision is made over the arm and the subcutaneous tissue is split, and the fascia over the triceps muscle is split. Since it is a myxoma, the triceps are retracted to one side and dissected off the posterior portion of the ulnar nerve traveling down the medial portion of the incision. The radial nerve, which is crossing distally in the wound from medial to lateral, is protected. The vessels traveling with the radial nerve are protected. Several perforators off the profunda brachial artery are ligated and incised. Once this interval is freed up, deeper dissection is carried down into the deep triceps and exposure is made over the mass overlying the humerus. The mass is homogenous in consistency and dissection is accomplished by retracting the triceps up off the humerus and taking the mass off of the posterior aspect of the humerus. Superiorly in the wound, some of the vessels and part of the axillary nerve innervating the inferior deltoid are retracted to gain exposure to that portion of the wound. The mass is taken out in one piece. It is inspected intra-operatively and found to be consistent with a myxoma. It is handed off the operative field. The wound is then copiously irrigated. Retractors are removed, protecting both the ulnar nerve

medially and the radial nerve inferiorly in the wound. The tourniquet is let down. Hemostasis is obtained and a drain is placed. A multilayered closure is performed.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. T specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologis coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of a sling. Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	24076					
Sample Size:	100	**Resp N:**	42	**Response:** 42.0 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**4.00**	6.00	25.00
Survey RVW:	6.00	7.50	**9.00**	11.50	18.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	24076	**Recommended Physician Work RVU: 7.28**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)	CPT Code: 24076	Key Reference CPT Code: 25109	Source of Time RUC Time
Median Pre-Service Time	68.00	50.00	
Median Intra-Service Time	60.00	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	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**229.00**	**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	3.50	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.67
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.83	2.67
Physical effort required	2.67	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.83	2.67
Outcome depends on the skill and judgment of physician	2.67	2.67
Estimated risk of malpractice suit with poor outcome	2.83	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.50
Intra-Service intensity/complexity	2.67	2.50
Post-Service intensity/complexity	2.67	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 24076 (Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P36 and P37). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted, including no positioning time.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning after induction of anesthesia in supine position.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 7.28 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.043. This is less than the IWPUT for the reference code 25109, which has less intra and total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 24076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24073 Tracking Number P37 Specialty Society Recommended RVU: **11.30**

Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male undergoes excision of a 6 cm myxoma from between the humerus and triceps.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 7% , Kept overnight (less than 24 hours) 69% , Admitted (more than 24 hours) 24%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 90%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A posterior incision is made over the arm and the subcutaneous tissue is split, and the fascia over the triceps muscle is split. Since it is a myxoma, the triceps are retracted to one side and dissected off the posterior portion of the ulnar nerve traveling down the medial portion of the incision. The radial nerve, which is crossing distally in the wound from medial to lateral, is protected. The vessels traveling with the radial nerve are protected. Several perforators off the profunda brachial artery are ligated and incised. Once this interval is freed up, deeper dissection is carried down into the deep triceps and exposure is made over the mass overlying the humerus. The mass is homogenous in consistency and dissection is accomplished by retracting the triceps up off the humerus and taking the mass off of the posterior aspect of the humerus. Superiorly in the wound, some of the vessels and part of the axillary nerve innervating the inferior deltoid are retracted to gain exposure to that portion of the wound. The mass is taken out in one piece. It is inspected intra-operatively and found to be consistent with a myxoma. It is handed off the operative field. The wound is then copiously irrigated. Retractors are removed, protecting both the ulnar nerve

medially and the radial nerve inferiorly in the wound. The tourniquet is let down. Hemostasis is obtained and a drain is placed. A multilayered closure is performed.

Description of Post-Service Work: Apply soft dressing and sling. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	24073					
Sample Size:	100	**Resp N:**	42	**Response:** 42.0 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**4.00**	5.00	15.00
Survey RVW:	7.00	11.63	**13.00**	15.75	22.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**75.00**	90.00	140.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	24073	**Recommended Physician Work RVU: 11.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)	**CPT Code: 24073**	**Key Reference CPT Code:** 25609	**Source of Time** RUC Time
Median Pre-Service Time	68.00	65.00	
Median Intra-Service Time	75.00	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	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	62.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**283.00**	**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	3.88	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.25
Urgency of medical decision making	3.75	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.13
Physical effort required	3.13	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	3.88	3.25
Estimated risk of malpractice suit with poor outcome	3.25	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.63	2.75
Intra-Service intensity/complexity	3.25	2.88
Post-Service intensity/complexity	3.50	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 24076 (Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P36 and P37). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were poorly predicted, including no positioning time.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning after induction of anesthesia in supine position.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 11.30 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.067. This is similar to the IWPUT for the reference code 25609, which technically more demanding.

SERVICES REPORTED WITH MULTIPLE 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) 24076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 25115

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

medially and the radial nerve inferiorly in the wound. The tourniquet is let down. Hemostasis is obtained and a drain is placed. A multilayered closure is performed.

Description of Post-Service Work: Apply soft dressing and sling. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	24073				
Sample Size: 100	**Resp N:** 42	**Response:** 42.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	2.00	**4.00**	5.00	15.00
Survey RVW:	7.00	11.63	**13.00**	15.75	22.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**75.00**	90.00	140.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	24073	**Recommended Physician Work RVU: 11.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.0 %

TIME ESTIMATES (Median)	CPT Code: 24073	Key Reference CPT Code: 25609	Source of Time RUC Time
Median Pre-Service Time	68.00	65.00	
Median Intra-Service Time	75.00	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	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	62.0	124.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**283.00**	**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	3.88	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.25
Urgency of medical decision making	3.75	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.13
Physical effort required	3.13	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	3.88	3.25
Estimated risk of malpractice suit with poor outcome	3.25	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.63	2.75
Intra-Service intensity/complexity	3.25	2.88
Post-Service intensity/complexity	3.50	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 24076 (Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P36 and P37). During the Harvard study, 13 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were poorly predicted, including no positioning time.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning after induction of anesthesia in supine position.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 11.30 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.067. This is similar to the IWPUT for the reference code 25609, which technically more demanding.

SERVICES REPORTED WITH MULTIPLE 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) 24076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25076 Tracking Number P44 Specialty Society Recommended RVU: **6.61**

Global Period: 090 RUC Recommended RVU: **6.61**

CPT Descriptor: Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old male undergoes excision of a 2 cm lipoma from the volar compartment of the forearm.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 0%, In the office 5%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 87% , Kept overnight (less than 24 hours) 9% , Admitted (more than 24 hours) 2%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the tumor. Careful dissection is carried through the subcutaneous tissue and fascia to the tumor taking care to protect any neurovascular structures. The tumor is dissected away from the adjacent tissues and removed. The wound is irrigated. The tourniquet is released and meticulous hemostasis is achieved. The wound is again irrigated. The wound is closed in layers.

Description of Post-Service Work: Apply soft dressing and splint to hold the wrist in neutral alignment. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other

professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, includ discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the r day to assess the wound and neurovascular status and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures and drain; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS					
Specialty(s):	general surgery; orthopaedic surgery; general & orthopaedic surgical oncology; hand surgery; plastic surgery					
CPT Code:	25076					
Sample Size:	150	**Resp N:**	58	**Response:** 38.6 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	8.00	30.00
Survey RVW:	4.00	6.50	**6.81**	8.88	15.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	30.00	**45.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	25076	**Recommended Physician Work RVU: 6.61**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 17.2 %

TIME ESTIMATES (Median)	CPT Code: 25076	Key Reference CPT Code: 25109	Source of Time RUC Time
Median Pre-Service Time	60.00	50.00	
Median Intra-Service Time	45.00	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	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**206.00**	**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	3.10	2.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.70
Urgency of medical decision making	2.80	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.90	2.90
Physical effort required	2.40	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.80
Outcome depends on the skill and judgment of physician	2.70	2.80
Estimated risk of malpractice suit with poor outcome	3.20	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.20	3.10
Intra-Service intensity/complexity	2.90	2.90
Post-Service intensity/complexity	2.40	2.30

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 25076 (Excision, tumor, soft tissue of forearm and/or wrist area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P44 and P45). During the Harvard study, 12 orthopaedic surgeons were surveyed. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 6.61 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.047. This is less than the IWPUT for the reference code 25109, which has slightly less intra-operative time and less total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 25076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25073 · Tracking Number P45 Specialty Society Recommended RVU: **8.26**

Global Period: 090 RUC Recommended RVU: **7.00**

CPT Descriptor: Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old male undergoes excision of a 6 cm lipoma from the volar compartment of the forearm.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 67% , Kept overnight (less than 24 hours) 30% , Admitted (more than 24 hours) 4%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 82%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on the upper arm. Prep and drape the arm. Scrub and gown. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made distal to the flexor crease of the elbow down the volar aspect of the forearm. The subcutaneous tissue is incised and the fascia is split. Care is taken to avoid any of the antebrachial cutaneus nerves of the forearm. The interval between the brachial radialis muscle and the flexor carpi radialis muscle is split. The radial artery on the lateral side of the incision along with the radial sensory nerve are dissected free and retracted laterally. The flexor digitorum sublimis muscle is identified and several perforating vessels off the radial artery are ligated and tied. The lateral aspect of the flexor digitorum sublimis is released and a portion of the distal pronator teres muscle incised and retracted proximally. Next, the flexor digitorum superficialis is retracted toward the ulnar side of the arm. The median nerve and the anterior interosseous nerve and artery are exposed. The anterior interosseous innervation to the flexor digitorum profundus and flexor pollicis longus are identified and protected. A portion of the profundus is longitudinally split to expose the lipoma. The lipoma is deep and just sitting on the ulna and interosseous membrane. The median nerve is carefully protected along with the ulnar artery while splitting the flexor digitorum

profundus. Very careful dissection is necessary to remove this deep lipoma. It is removed off the interosseous membrane as well as off the ulna. The tumor is removed in one piece. The flexor digitorum profundus is then loosely closed with interrupted sutures. The anterior interosseous and medial nerves are carefully inspected. The tourniquet is let down and bleeders are ligated. The flexor digitorum is allowed to gently be put back into place laterally and held with interrupted re-absorbable sutures. A portion of a pronator teres tendon that had been released is repaired with a non-absorbable suture. A drain is placed in this layer and brought out through the skin. The retractors are all removed and the brachial radialis and flexor carpi radialis are allowed to fall back into place. The fascia is left open. The wound is closed in layers.

Description of Post-Service Work: Apply soft dressing and splint to hold the wrist in neutral alignment. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day to assess the open wound and neurovascular status and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures an drain; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; orthopaedic surgery; general & orthopaedic surgical oncology; hand surgery; plastic surgery				
CPT Code:	25073				
Sample Size:	150	**Resp N:**	58	**Response:** 38.6 %	
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:	5.00	7.50	**8.50**	11.38	18.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	45.00	**60.00**	75.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	25073	**Recommended Physician Work RVU: 8.26**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
25115	090	9.89	**RUC Time**

CPT Descriptor Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 17.2 %

TIME ESTIMATES (Median)	CPT Code: 25073	Key Reference CPT Code: 25115	Source of Time RUC Time
Median Pre-Service Time	60.00	45.00	
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	0.00	
Median Office Visit Time	62.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**221.00**	**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	3.60	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.10
Urgency of medical decision making	3.00	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.30
Physical effort required	3.00	2.90

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.30	2.90
Outcome depends on the skill and judgment of physician	3.60	3.30
Estimated risk of malpractice suit with poor outcome	3.30	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.30	2.90
Intra-Service intensity/complexity	3.20	3.30
Post-Service intensity/complexity	2.60	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 25076 (Excision, tumor, soft tissue of forearm and/or wrist area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P44 and P45). During the Harvard study, 12 orthopaedic surgeons were surveyed. Pre and post times were predicted. This prediction resulted in no positioning time and no facility post-work (even though the code is typically performed in a facility).

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 8.26 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.062. This is greater than the IWPUT for the reference code 25515, and reflects the more demanding deep excision.

SERVICES REPORTED WITH MULTIPLE 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) 25076

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 26545

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:26116 Tracking Number P51 Specialty Society Recommended RVU: **6.61**

Global Period: 090 RUC Recommended RVU: **6.61**

CPT Descriptor: Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male undergoes excision of a 1.2 cm tumor of the thenar muscles of the right hand.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 94% , In the ASC 0%, In the office 6%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 90% , Kept overnight (less than 24 hours) 8% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 80%

.s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the thenar eminence. The subcutaneous tissue is dissected. The thenar fascia is opened. The flexor pollicis brevis muscle fibers are split to expose the tumor. Care is taken to avoid injury to the motor branch of the median nerve. The tumor and its capsule are excised. The tourniquet is released and meticulous hemostasis is achieved using a bipolar electrocautery. The wound is inspected and irrigated. The wound closed.

Description of Post-Service Work: Apply soft protective dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular

status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Recon medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; hand surgery; plastic surgery				
CPT Code:	26116				
Sample Size:	120	**Resp N:**	64	**Response:** 53.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**6.00**	15.00	60.00
Survey RVW:	2.25	5.95	**6.81**	9.00	16.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	30.00	**45.00**	45.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	26116	**Recommended Physician Work RVU: 6.61**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 17.1 %

TIME ESTIMATES (Median)	CPT Code: 26116	Key Reference CPT Code: 25109	Source of Time RUC Time
Median Pre-Service Time	60.00	50.00	
Median Intra-Service Time	45.00	40.00	
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	19.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**201.00**	**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	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.45	2.36
Urgency of medical decision making	2.55	2.64

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.91
Physical effort required	2.36	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.82	2.82
Outcome depends on the skill and judgment of physician	3.09	3.09
Estimated risk of malpractice suit with poor outcome	3.09	2.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.64	2.64
Intra-Service intensity/complexity	3.09	2.82
Post-Service intensity/complexity	2.36	2.36

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 26116 (Excision, tumor or vascular malformation, soft tissue of hand or finger; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P51 and P52). During the Harvard study, 14 orthopaedic surgeons were surveyed. Hand surgery and plastic surgery were not included in the review. No positioning time was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 6.61 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.049. This RVW is the same as the reference code 25109. Total work for both codes is very similar.

SERVICES REPORTED WITH MULTIPLE 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) 26116

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26113 Tracking Number P52 Specialty Society Recommended RVU: **7.77**

Global Period: 090 RUC Recommended RVU: **7.00**

CPT Descriptor: Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male presents with a 3.5 cm tumor in the thenar muscles of the left hand. At operation, the tumor and adjacent soft tissue are excised.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 89% , Kept overnight (less than 24 hours) 6% , Admitted (more than 24 hours) 5%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 75%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the thenar eminence. The subcutaneous tissue is dissected. The thenar fascia is opened. The flexor pollicis brevis muscle fibers are split to expose the tumor. Care is taken to avoid injury to the motor branch of the median nerve. The tumor and its capsule are excised. The tourniquet is released and meticulous hemostasis is achieved using a bipolar electrocautery. The wound is inspected and irrigated. The wound is closed.

Description of Post-Service Work: Apply soft protective dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular

status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS		
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; hand surgery; plastic surgery		
CPT Code:	26113		
Sample Size:	120	**Resp N:** 64	**Response:** 53.3 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	40.00
Survey RVW:	3.10	6.95	**8.00**	10.00	18.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	40.00	**58.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	26113	**Recommended Physician Work RVU: 7.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**58.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

's 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 12.5 %

TIME ESTIMATES (Median)	CPT Code: 26113	Key Reference CPT Code: 25109	Source of Time RUC Time
Median Pre-Service Time	60.00	50.00	
Median Intra-Service Time	58.00	40.00	
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	19.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**214.00**	**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	2.75	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.63	2.25
Urgency of medical decision making	2.38	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.88	2.88
Physical effort required	2.63	2.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.88	2.75
Outcome depends on the skill and judgment of physician	2.88	2.88
Estimated risk of malpractice suit with poor outcome	2.88	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.88	2.88
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.63	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 26616 (Excision, tumor or vascular malformation, soft tissue of hand or finger; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P51 and P52). During the Harvard study, 14 orthopaedic surgeons were surveyed. Hand surgery and plastic surgery were not included in the review. No positioning time was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 7.77 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.058. This is the same as the IWPUT for the reference code 25109. The difference in RVW reflects the additional intra-operative time required.

SERVICES REPORTED WITH MULTIPLE 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) 26116

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27048 Tracking Number P60 Specialty Society Recommended RVU: **8.74**

Global Period: 090 RUC Recommended RVU: **8.74**

CPT Descriptor: Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female undergoes excision of a 4 cm lipoma deep in the gluteus maximus.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 46% , Kept overnight (less than 24 hours) 51% , Admitted (more than 24 hours) 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 78%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery. The gluteus maximus muscle is exposed around the tumor. The tumor is excised along with surrounding muscle using electrocautery and dissection. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. Devitalized muscle is debrided. Where possible, the muscle fascial defect is approximated. A Penrose drain is placed in the cavitary defect. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and

discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relev data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval c charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	27048					
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**5.00**	9.00	25.00
Survey RVW:		5.00	7.50	**9.00**	12.00	20.00
Pre-Service Evaluation Time:				**40.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		25.00	60.00	**75.00**	85.00	120.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27048	**Recommended Physician Work RVU: 8.74**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**75.00**		
Immediate Post Service-Time:	**20.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
15100	090	9.74	**RUC Time**

CPT Descriptor Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 17.1 %

TIME ESTIMATES (Median)	**CPT Code: 27048**	**Key Reference CPT Code: 15100**	**Source of Time RUC Time**
Median Pre-Service Time	80.00	65.00	
Median Intra-Service Time	75.00	60.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**288.00**	**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	2.67	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	1.83
Urgency of medical decision making	2.33	1.83

Technical Skill/Physical Effort (Mean)

Technical skill required	2.83	2.17
Physical effort required	2.17	2.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.17
Outcome depends on the skill and judgment of physician	3.00	2.33
Estimated risk of malpractice suit with poor outcome	3.00	2.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.17	2.00
Intra-Service intensity/complexity	2.83	2.50
Post-Service intensity/complexity	2.17	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27048 (Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular) will be deleted in 2010 and replaced by two new codes (P60 and P61). During the Harvard study, 8 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for lateral positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 8.74 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.039. This is less than the IWPUT for the reference code 15100, which has less intra-operative time, more post work, and similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27048

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27045 Tracking Number P61 Specialty Society Recommended RVU: **12.63**

Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female undergoes excision of an 8 cm lipoma deep in the gluteus maximus.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 6% , Kept overnight (less than 24 hours) 57% , Admitted (more than 24 hours) 37%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 80%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. 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: In incision is made from the greater trochanter up toward the posterior superior iliac spine. The subcutaneous tissue is split and the fascia of the iliac tibial band and the gluteus maximus is identified and split. The gluteus maximus muscle is very carefully split proximally and several perforating vessels off the inferior gluteal artery are ligated and tied. Once that is done, self retaining retractors are put into the gluteus maximus muscle and a portion of the mass is seen. The greater trochanter is exposed in the distal portion of the wound and the lipoma is released very carefully over the greater trochanter. Dissection of the lipoma off the posterior aspect of the gluteus medius is then performed. Distally in the wound the sciatic nerve is identified underneath the lipoma. Very carefu' dissection is performed to remove the lipoma from on top of the sciatic nerve. The inferior gluteal nerve, artery a vein are perforating the gluteus maximus in the distal portion of the wound. They are also identified, dissected out an protected. Several branches off the inferior gluteal vessels are ligated and incised. The remainder of the lipoma is released off the deep surface of the gluteus maximus up toward the sciatic notch. Anteriorly, the remainder of the lipoma is removed off the back of the gluteus medius. Now the lipoma is attached only near the sciatic notch. The superior gluteal artery and vein are coming around the superior corner of the sciatic notch. Several vessels perforating

the lipoma coming off the superior gluteal vessels are ligated and tied. Once that is done, dissection can be done to release the lipoma off the gluteal vessels. The remainder of the lipoma near the sciatic notch is very slowly released. The inferior gluteal vessels can be seen by the sciatic notch and are carefully protected. The sciatic nerve is been carefully protected along with the piriformis tendon coming through the notch. The mass is then removed in one piece. The wound is copiously irrigated and the area is inspected to be certain there no residual tumor. The specimen is handed off the field. A deep drain is placed and brought out the gluteus maximus. The wound is closed layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	27045				
Sample Size: 100	**Resp N:** 35	**Response:** 35.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**4.00**	5.00	30.00
Survey RVW:	8.00	11.00	**13.00**	16.00	30.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	60.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27045	**Recommended Physician Work RVU: 12.63**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
47100	090	12.78	**RUC Time**

CPT Descriptor Biopsy of liver, wedge

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	CPT Code: 27045	Key Reference CPT Code: 47100	Source of Time RUC Time
Median Pre-Service Time	80.00	75.00	
Median Intra-Service Time	90.00	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	80.00	
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	**320.00**	**345.00**	
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	3.86	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.00
Urgency of medical decision making	3.14	2.86

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	3.71
Physical effort required	3.57	3.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.43	3.29
Outcome depends on the skill and judgment of physician	4.14	3.86
Estimated risk of malpractice suit with poor outcome	3.43	3.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.57	3.29
Intra-Service intensity/complexity	4.00	3.86
Post-Service intensity/complexity	2.86	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27048 (Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular) will be deleted in 2010 and replaced by two new codes (P60 and P61). During the Harvard study, 8 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for lateral positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 12.63 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.068. This is similar to the IWPUT for the reference code 47100, which has less intra-operative time and similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27048

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27328 Tracking Number P70 Specialty Society Recommended RVU: **8.74**

Global Period: 090 RUC Recommended RVU: **8.74**

CPT Descriptor: Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 39-year-old male undergoes excision of a 3.5 cm tumor posterior to the knee joint that is pigmented villonodular synovitis.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 40% , Kept overnight (less than 24 hours) 45% , Admitted (more than 24 hours) 14%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 6cm incision is made over the tumor on the posterior knee. The subcutaneous tissue is opened and the fascia over the popliteal space is split. The tumor is identified between the semimembranosus and the medial head of the gastrocnemius muscles. The neurovascular bundle is retracted laterally. Dissection is carried around the mass and the mass is released off of the muscles. The tumor is released from the posterior knee capsule. The tumor is handed off of the field. The wound is inspected and irrigated. The posterior capsule is repaired. A deep drain is placed. The fascia is carefully closed. The superficial wound is closed in layers with interrupted sutures.

Description of Post-Service Work: A compressive dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the leg to prevent hematoma formation. A knee immobilizer is applied. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor

patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focu exam, assessing the open wound status drain. Assess neurovascular status. Wound care and close observation . important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery				
CPT Code:	27328				
Sample Size: 120	**Resp N:** 42	**Response:** 35.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	1.00	5.00	**8.00**	15.00	50.00
Survey RVW:	7.00	9.00	**11.50**	15.00	30.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	60.00	**60.00**	75.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	27328	**Recommended Physician Work RVU: 8.74**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
15100	090	9.74	**RUC Time**

CPT Descriptor Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 21.4 %

TIME ESTIMATES (Median)	**CPT Code: 27328**	**Key Reference CPT Code: 15100**	**Source of Time RUC Time**
Median Pre-Service Time	68.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**261.00**	**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	3.11	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	2.78
Urgency of medical decision making	3.33	2.78

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	3.33
Physical effort required	3.22	3.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.11
Outcome depends on the skill and judgment of physician	3.44	3.22
Estimated risk of malpractice suit with poor outcome	3.56	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.89	2.67
Intra-Service intensity/complexity	2.89	2.78
Post-Service intensity/complexity	2.89	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27328 (Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular) will be deleted in 2010 and replaced by two new codes (P70 and P71). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. No positioning time was recorded. Facility work was underestimated.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 8.74 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.052. This is similar to the IWPUT for the reference code 15100, which has the same intra-operative time and similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27328

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27339 Tracking Number P71 Specialty Society Recommended RVU: **12.27**

Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 39-year-old male undergoes excision of a 10 cm tumor posterior to the knee joint that is pigmented villonodular synovitis.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 7% , Kept overnight (less than 24 hours) 40% , Admitted (more than 24 hours) 52%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 88%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A 13 cm incision curving across the posterior knee crease is performed. The subcutaneous flaps are raised and the fascia is split. The cutaneous branches of the sural nerve in the midline of the calf are carefully protected. A large brownish mass is identified and dissected off the surrounding tissues. Since it is coming off the posterior knee joint, dissection is gradually carried down toward the knee. The semi-membranous tendon is retracted medially and the mass indeed comes out lateral rather than medial to the medial head of the gastrocnemius muscle. The medial head of the gastrocnemius muscle is retracted and then since the mass is lateral, care is taken to protect the innervation to the medial head of the gastrocnemius muscle as well as to the tibia nerve, popliteal artery a popliteal vein. The mass is mobilized off the lateral head of the gastrocnemius muscle. It is also mobilized distally on the proximal end of the soleus. A small portion of proximal soleus is released to allow the tibia nerve and the popliteal vessels to be retracted. The popliteal vessels are retracted laterally along with the tibial nerve, exposing the posterior knee joint. The mass is taken down directly until it enters the posterior knee joint under the medial head of the gastrocnemius. The mass is removed. A deep drain is placed. The medial and lateral heads of the gastroc muscle

along with the neurovascular bundle are allowed to fall back into place. Several small branches of the popliteal artery had to be ligated to expose this portion of the joint. The remainder of the fascia is left open to prevent compartment syndrome in the superficial posterior compartment. Absorbable sutures are used on the subcutaneous and interrupted nylons are used on the skin.

Description of Post-Service Work: A compressive dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the leg to prevent hematoma formation. A knee immobilizer is applied. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing the open wound status drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery		
CPT Code:	27339		
Sample Size:	120	**Resp N:** 42	**Response:** 35.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	20.00	50.00
Survey RVW:	8.00	12.63	**15.00**	18.00	35.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	63.00	**90.00**	90.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27339	**Recommended Physician Work RVU: 12.27**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
's this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27880	090	15.24	RUC Time

CPT Descriptor Amputation, leg, through 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 21.4 %

TIME ESTIMATES (Median)	CPT Code: 27339	Key Reference CPT Code: 27880	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	90.00	80.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	140.00	
ledian Discharge Day Management Time	38.0	38.00	
ledian Office Visit Time	62.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**310.00**	**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	4.50	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	3.00
Urgency of medical decision making	3.88	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	3.13
Physical effort required	3.88	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.25	3.38
Outcome depends on the skill and judgment of physician	4.63	3.25
Estimated risk of malpractice suit with poor outcome	4.50	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.75	3.25
Intra-Service intensity/complexity	3.75	3.25
Post-Service intensity/complexity	3.75	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27328 (Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular) will be deleted in 2010 and replaced by two new codes (P70 and P71). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. No positioning time was recorded. Facility work was underestimated.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 12.27 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.066. This is greater than the IWPUT for the reference code 27880 and reflects the more complex work. The RVW is less than the reference code accounting for less post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27328

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27619 Tracking Number P79 Specialty Society Recommended RVU: **6.80**

Global Period: 090 RUC Recommended RVU: **6.80**

CPT Descriptor: Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old female undergoes excision of a 3.5 cm lipoma on the interosseous membrane deep to the anterior and lateral compartments of the leg.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 75% , Kept overnight (less than 24 hours) 21% , Admitted (more than 24 hours) 4%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 80%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 7 cm skin incision is made just anterior to the fibula. The subcutaneous tissue is split and the fascia is split. The muscles of the anterior compartment of the leg are identified and are retracted anteriorly off of the interosseus membrane. Any perforating vessels are ligated and tied. The tumor is carefully dissected off the interosseus membrane protecting the deep structures of the leg. The tumor is sent to pathology. The wound is irrigated and inspected. The fascia is left open to prevent compartment syndrome. A drain is placed. The tourniquet is deflated and any bleeders are cauterized.

Description of Post-Service Work: Apply sterile dressings and splint. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks

and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and appropriate use of crutches or walker. Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and at several more visits through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures and drain; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	27619				
Sample Size:	150	**Resp N:**	49	**Response:** 32.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	5.00	50.00
Survey RVW:	4.00	7.00	**8.40**	12.00	18.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	40.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	27619	**Recommended Physician Work RVU: 6.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**23.00**	**3.00**	**20.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
15100	090	9.74	**RUC Time**

CPT Descriptor Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)	**CPT Code: 27619**	**Key Reference CPT Code:** 15100	**Source of Time** RUC Time
Median Pre-Service Time	71.00	65.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	55.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**225.00**	**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	3.14	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.43
Urgency of medical decision making	3.43	3.29

Technical Skill/Physical Effort (Mean)

Technical skill required	3.71	3.71
Physical effort required	3.43	3.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	3.43
Outcome depends on the skill and judgment of physician	3.71	3.86
Estimated risk of malpractice suit with poor outcome	4.00	3.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	2.86
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.86	2.57

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27619 (Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P79 and P80). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery and podiatry were not involved. Pre and post times were predicted. No positioning time was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 20 minutes for prone positioning and application of a tourniquet
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 6.80 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.042. This is less than the IWPUT for the reference code 15100. The difference in RVW reflects the additional post-operative work required.

SERVICES REPORTED WITH MULTIPLE 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) 27619

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 25109

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:27634 Tracking Number P80 Specialty Society Recommended RVU: **10.20**

Global Period: 090 RUC Recommended RVU: **10.00**

CPT Descriptor: Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old female undergoes excision of a 7.5 cm lipoma on the interosseous membrane deep to the anterior and lateral compartments of the leg.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 35% , Kept overnight (less than 24 hours) 49% , Admitted (more than 24 hours) 16%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 83%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 10 cm skin incision is made just anterior to the fibula. The subcutaneous tissue is split and the fascia is split. The muscles of the anterior compartment of the leg are identified and are retracted anteriorly off of the interosseus membrane. The tumor is carefully dissected off the interosseus membrane protecting the deep structures of the leg. Any perforating vessels are ligated and tied. The tumor is sent to pathology. The wound is irrigated and inspected. The fascia is left open to prevent compartment syndrome. A drain is placed. The tourniquet is deflated and any bleeders are cauterized.

Description of Post-Service Work: Apply sterile dressings and splint. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss

ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	27634				
Sample Size:	150	**Resp N:**	49	**Response:** 32.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	5.00	30.00
Survey RVW:	5.93	9.25	**10.50**	14.00	23.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	25.00	50.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	27634	**Recommended Physician Work RVU: 10.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**23.00**	**3.00**	**20.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

; this new/revised procedure considered to be a new technology or service? No

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)	CPT Code: 27634	Key Reference CPT Code: 28299	Source of Time RUC Time
Median Pre-Service Time	71.00	75.00	
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	
'edian Discharge Day Management Time	38.0	19.00	
,edian Office Visit Time	62.0	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	3.43	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.43
Urgency of medical decision making	3.14	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	3.57	3.29
Physical effort required	3.00	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	3.29
Outcome depends on the skill and judgment of physician	3.86	3.43
Estimated risk of malpractice suit with poor outcome	3.29	3.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	3.00
Intra-Service intensity/complexity	3.57	3.29
Post-Service intensity/complexity	2.43	2.57

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27619 (Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)) will be deleted in 2010 and replaced by two new codes (P79 and P80). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery and podiatry were not involved. Pre and post times were predicted. No positioning time was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: Add 10 minutes for additional review of imaging, pathology and consultation with other health professionals for reconstruction.
- Positioning: Add 20 minutes for prone positioning and application of a tourniquet
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 10.20 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.055. This is similar to the IWPUT for the reference code 28299. The difference in RVW accounts for less intra-op time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 27619

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28045 Tracking Number P88 Specialty Society Recommended RVU: **5.34**

Global Period: 090 RUC Recommended RVU: **5.34**

CPT Descriptor: Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male undergoes excision of a 1.2 cm hemangioma in the deep plantar space of the foot.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 90% , In the ASC 0%, In the office 10%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 81% , Kept overnight (less than 24 hours) 19% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 88%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made on the plantar aspect of the right arch. Dissection is carried out to reveal a 1.2 cm in diameter purplish lesion. The tumor is dissected from surrounding tissue, and all bleeders are cauterized. The lesion is delivered from the wound. The wound site is irrigated and inspected. The wound is closed in layers with simple interrupted sutures and the skin is coapted with a running mattress of nylon. The tourniquet is deflated, and normal capillary return is seen in the toes.

Description of Post-Service Work: Apply compression dressing and splint/shoe. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile

medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days and for several more visits through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss patholo report when available. Order and review periodic lab and/or imaging, as necessary. Reconcile medication(s). Ass functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	28045				
Sample Size: 120	**Resp N:** 48	**Response:** 40.0 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	6.00	50.00
Survey RVW:	2.25	5.50	**8.23**	9.81	16.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	56.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	28045	**Recommended Physician Work RVU: 5.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**6.00**	**1.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
13121	010	4.36	**RUC Time**

CPT Descriptor Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 14.5 %

TIME ESTIMATES (Median)	**CPT Code: 28045**	**Key Reference CPT Code: 13121**	**Source of Time RUC Time**
Median Pre-Service Time	30.00	10.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	55.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**169.00**	**117.00**	
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	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.57
Urgency of medical decision making	2.14	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	3.14
Physical effort required	3.00	3.00

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	3.43	3.00
Estimated risk of malpractice suit with poor outcome	3.14	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.86
Intra-Service intensity/complexity	2.86	2.57
Post-Service intensity/complexity	2.43	2.29

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 28045 (Excision, tumor, foot; deep, subfascial, intramuscular) will be deleted in 2010 and replaced by two new codes (P88 and P89). During the Harvard study, 10 orthopaedic surgeons were surveyed. Podiatry, the primary and significant provider of this service, was not involved. Pre and post times were predicted. No positioning work was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: No change. The 5 minutes allocated for moderate sedation by an anesthesiologist is replaced by 5 minutes for the surgeon to perform a regional block.
- Positioning: Add 5 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 5.34 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.041. This is similar to the IWPUT for the reference code 13121. The RVW is greater than the reference code, accounting for more post work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28045

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28041 Tracking Number P89 Specialty Society Recommended RVU: **8.26**

Global Period: 090 RUC Recommended RVU: **7.00**

CPT Descriptor: Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male undergoes excision of a 5 cm hemangioma in the deep plantar space of the foot.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 96% , In the ASC 0%, In the office 4%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 65% , Kept overnight (less than 24 hours) 28% , Admitted (more than 24 hours) 7%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 77%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A curvilinear incision is made on the sole of the foot. The subcutaneous tissue is incised and the plantar fascia is split. The lateral plantar nerve and artery are identified in the wound as they come through the medial side of the foot. The aponeurosis of the plantar fascia is also identified and is split along the medial side to allow access to the sole of the foot. The flexor digitorum brevis muscle is retracted laterally and a portion of it is released off the anterior calcaneus. This allows clear exposure of the lateral plantar nerve and artery and the medial plantar nerve and artery. The mass is just between the two nerves and is noted to be wrapping around the interval at the medial side of the quadratus plantae muscle. The flexor digitorum longus tendon is mobilized off the quadratus plantae and retracted medially. The quadratus plantae muscle is retracted laterally and the mass is exposed. Careful resection performed to remove the mass from the space in one piece. The flexor hallucis tendon is mobilized medially. The tumor is dissected off the abductor hallucis muscle. Once it is removed, the flexor digitorum is allowed to fall back into position as well as the quadratus plantae muscle. Both the medial plantar artery and nerve and the lateral plantar artery and nerve are inspected. The flexor digitorum brevis muscle is allowed to fall back into position and several absorbable sutures are put into the base where it was released partially off the calcaneus. The plantar aponeurosis is left to fall back

into place. Any branches of the medial plantar artery that perforated the septum are ligated. The fascia is closed with interrupted suture. The subcutaneous wound is closed with absorbable suture. Nylon is used in the curvilinear incision on the sole of the foot.

Description of Post-Service Work: A compressive foot dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the foot to prevent hematoma formation. Apply splint. Transfer patient to the recovery room. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days and for several more visits through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Reconcile medication(s). Assess functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	28041				
Sample Size: 120	**Resp N:** 48	**Response:** 40.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	2.00	**3.00**	5.00	50.00
Survey RVW:	2.50	6.10	**8.50**	10.25	18.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28041	**Recommended Physician Work RVU: 8.26**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

s 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

)ther Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 12.5 %

TIME ESTIMATES (Median)	CPT Code: 28041	Key Reference CPT Code: 29891	Source of Time RUC Time
Median Pre-Service Time	56.00	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	
ledian Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	62.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**217.00**	**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	3.83	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.33
Urgency of medical decision making	3.67	3.40

Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	4.00
Physical effort required	3.33	3.67

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	3.67	3.67
Estimated risk of malpractice suit with poor outcome	3.50	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.83	2.87
Intra-Service intensity/complexity	3.67	3.33
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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 28045 (Excision, tumor, foot; deep, subfascial, intramuscular) will be deleted in 2010 and replaced by two new codes (P88 and P89). During the Harvard study, 10 orthopaedic surgeons were surveyed. Podiatry, the primary and significant provider of this service, was not involved. Pre and post times were predicted. No positioning work was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 8.26 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.064. This is similar to the IWPUT for the reference code 29891. The RVW is less than the reference code, accounting for less post work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28045

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21015 Tracking Number P5 Specialty Society Recommended RVU: **9.71**

Global Period: 090 RUC Recommended RVU: **9.71**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents with a 1.5 cm sarcoma of the jaw muscles. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 51% , Kept overnight (less than 24 hours) 23% , Admitted (more than 24 hours) 26%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 60%

; moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic bolus and anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and stabilize the head. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Infiltrate a local anesthetic to reduce postoperative pain. A facial nerve monitor is positioned

Description of Intra-Service Work: A curvilinear incision is made in relaxed skin tension creases anterior to the auricle, extending inferiorly and then anteriorly into the upper neck, three centimeters below and parallel to the lower edge of the mandible. A subplatysmal flap is elevated over the submandibular triangle, more superiorly at the level of the parotid fascia, to expose the submandibular and parotid glands. Peripheral branches of the facial nerve, including the buccal and marginal mandibular branches, are identified and preserved. The flap is further extended anteriorly over the asseter muscle to expose the tumor. The tumor is removed en bloc, including a wide margin of masseter muscle and ny necessary surrounding structures, including skin at the previous biopsy site. The specimen is sent to pathology for frozen and permanent sections. The specimen is oriented for the pathologist, with direct communication between the surgeon and pathologist to ensure accurate pathologic interpretation. Frozen sections are taken from the surrounding tissue as indicated. Additional excision is carried out if necessary to obtain a clear margin. The wound is inspected and

irrigated. A deep drain is placed taking care to avoid contact with facial nerve branches. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied, held in place with a head w bandage. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. W. brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient and assess facial nerve and jaw function. Monitor for hematoma formation and intraoral edema. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing), and special attention to chewing / using jaw muscle. Reconcile medications and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within 1-2 days and for several more visits through the 90-day global period to remove dressings, assess wound healing, and redress wound; and remove drain and sutures. Discuss pathology report when available with the patient and family, as well as, recommendations for further evaluation, treatment, and monitoring as appropriate. Communicate with other physicians providing adjuvant treatment if indicated. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for speech/swallowing therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS; Martha Matthews, MD, FACS					
Specialty(s):	general surgery; otolaryngology; plastic surgery					
CPT Code:	21015					
Sample Size:	120	**Resp N:**	43	**Response:** 35.8 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**2.00**	4.00	30.00
Survey RVW:	6.00	7.50	**10.00**	12.00	18.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	60.00	**75.00**	90.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21015	**Recommended Physician Work RVU: 9.71**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38700	090	12.68	RUC Time

CPT Descriptor Suprahyoid lymphadenectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 20.9 %

TIME ESTIMATES (Median)	CPT Code: 21015	Key Reference CPT Code: 38700	Source of Time RUC Time
Median Pre-Service Time	68.00	60.00	
Median Intra-Service Time	75.00	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	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**277.00**	**300.00**	
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	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
Urgency of medical decision making	3.89	3.56

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.78
Physical effort required	3.56	3.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	3.78
Outcome depends on the skill and judgment of physician	4.22	4.11
Estimated risk of malpractice suit with poor outcome	3.78	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.78	3.78
Intra-Service intensity/complexity	3.78	3.78
Post-Service intensity/complexity	3.22	3.33

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21015 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp), will be deleted in 2010 and replaced by two new codes (P5 and P6). During the Harvard study, only 1 orthopaedic surgeon was surveyed. According to the PFS NPRM published in 1996, the RUC identified 21015 as potentially overvalued during the first 5-year-review. The RUC database indicates that AAOHNS presented comparable codes to show th 21015 was not overvalued. The time shown in the database in not validated survey time. Because the primary providers of this service were not involved in the Harvard review that predicted all time components, we believe the current RVW for this code is not based on relativity. The current RVW and the database time and visit information result in an IWPUT of 0.020, exceptionally low for a deep malignant tumor in the face/scalp.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable and stabilizing the head.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 9.71 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.053. This RVW and IWPUT is less than the reference code 38700, accounting for less intra-operative work and facility work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21015

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

pecialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21016 Tracking Number P6 Specialty Society Recommended RVU: **15.05**

Global Period: 090 RUC Recommended RVU: **15.05**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; 2 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents with a 6 cm sarcoma of the jaw muscles. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 7% , Kept overnight (less than 24 hours) 14% , Admitted (more than 24 hours) 79%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 67%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic bolus and anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and stabilize the head. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Infiltrate a local anesthetic to reduce postoperative pain. A facial nerve monitor is positioned.

Description of Intra-Service Work: A curvilinear incision is made in relaxed skin tension creases anterior to the auricle, extending inferiorly and then anteriorly into the upper neck, three centimeters below and parallel to the lower edge of the mandible. A subplatysmal flap is elevated over the submandibular triangle, more superiorly at the level of the parotid fascia, to expose the submandibular and parotid glands. Peripheral branches of the facial nerve, including the buccal and marginal mandibular branches, are identified and preserved. The flap is further extended anteriorly over t masseter muscle to expose the tumor. The parotid gland and peripheral branches of the facial nerve are retracted an the tumor is removed en bloc, including a wide margin of jaw musculature and any necessary surrounding structures, including skin at the previous biopsy site. The specimen is sent to pathology for frozen and permanent sections. The specimen is oriented for the pathologist, with direct communication between the surgeon and pathologist to ensure accurate pathologic interpretation. Frozen sections are taken from the surrounding tissue as indicated. Additional

excision is carried out if necessary to obtain a clear margin. The wound is inspected and irrigated. A deep drain is placed taking care to avoid contact with facial nerve branches. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied, held in place with a head wrap bandage. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, with attention to possible airway issues. After patient is awake, discuss surgery outcome with patient and assess facial nerve and jaw function. Monitor for hematoma formation and intraoral edema. Write orders for transferring to ICU and discuss ongoing care with nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing airway, hemodynamic status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, eating, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available with the patient and family, as well as, recommendations for further evaluation, treatment, and monitoring as appropriate. Communicate with other physicians providing adjuvant treatment if indicated Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for speech/swallowing therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; otolaryngology; plastic surgery				
CPT Code:	21016				
Sample Size:	120	**Resp N:**	43	**Response:** 35.8 %	
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:	6.50	12.55	**15.50**	19.00	26.86
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	35.00	90.00	**100.00**	145.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21016	**Recommended Physician Work RVU: 15.05**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
41130	090	15.51	RUC Time

CPT Descriptor Glossectomy; hemiglossectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 20.9 %

TIME ESTIMATES (Median)	CPT Code: 21016	Key Reference CPT Code: 41130	Source of Time RUC Time
Median Pre-Service Time	68.00	80.00	
Median Intra-Service Time	100.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	109.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**398.00**	**407.00**	
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	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.63
Urgency of medical decision making	4.00	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	4.00
Physical effort required	4.00	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.63
Outcome depends on the skill and judgment of physician	4.25	3.75
Estimated risk of malpractice suit with poor outcome	3.88	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.88	3.50
Intra-Service intensity/complexity	4.13	3.75
Post-Service intensity/complexity	3.50	3.13

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21015 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp), will be deleted in 2010 and replaced by two new codes (P5 and P6). During the Harvard study, only 1 orthopaedic surgeon was surveyed. According to the PFS NPRM published in 1996, the RUC identified 21015 as potentially overvalued during the first 5-year-review. The RUC database indicates that AAOHNS presented comparable codes to show that 21015 was not overvalued. The time shown in the database in not validated survey time. Because the primary providers of this service were not involved in the Harvard review that predicted all time components, we believe the current RVW for this code is not based on relativity. The current RVW and the database time and visit information result in an IWPUT of 0.020, exceptionally low for a deep malignant tumor in the face/scalp.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable and stabilizing the head.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 15.05 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.060. This RVW and IWPUT is less than the reference code 41130, a very comparable procedure in terms of time, intensity, complexity, and total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21015

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21557 Tracking Number P11 Specialty Society Recommended RVU: **14.57**

Global Period: 090 RUC Recommended RVU: **14.57**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old male presents with a 3 cm sarcoma near the sternocleidomastoid muscle in the neck. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 4% , Kept overnight (less than 24 hours) 36% , Admitted (more than 24 hours) 61%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 90%

ıs moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head rotated and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed. 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, an incision is made along the sternocleidomastoid muscle encompassing the overlying skin from the biopsy site. Subplatysmal flaps are raised. The tumor, attached to the sternocleidomastoid muscle, is isolated. Medially and superiorly, the internal jugular vein, carotid artery and vagus nerve are identified and retracted toward the midline. Laterally and posteriorly, the spinal accessory nerve is identified ithin the posterior triangle, and dissected free of the sternocleidomastoid muscle anteriorly to the internal jugular vein, ,reserving the nerve. Transection of the superior aspect of the sternocleidomastoid muscle, already partially transected by following the spinal accessory nerve, is completed with a wide margin around the tumor. Inferior to the tumor, the sternocleidomastoid muscle is likewise transected with a wide margin, separating the muscle from the internal jugular vein and omohyoid muscle. The deep aspect of the tumor and sternocleidomastoid muscle are then dissected free of the fascia investing the deep neck musculature and brachial plexus, taking care not to traumatize these structures, taking a

margin of fibrofatty tissue The specimen is sent to pathology for frozen and permanent sections. The specimen is oriented for the pathologist, with direct communication between the surgeon and pathologist to ensure accurate pathologic interpretation. Frozen sections are taken from the surrounding tissue as indicated. Additional excision is carried out if necessary to obtain a clear margin. The wound is inspected and irrigated. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied to the neck. Discuss postoperative care with recovery room staff. Assess hemodynamic, cranial nerve and drain function. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including determination of hematocrit, oxygenation status, and airway patency. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Discuss surgery outcome with patient. Perform an expanded problem focused exam, reassessing hemodynamic and airway status, cranial nerve, and drain function. Wound care and close observation are important to avoid or promptly treat wound hematoma. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drains when appropriate. Discuss pathology report with the patient and family, as well as, recommendations for further evaluation, treatment, and monitoring as appropriate. Communicate with other physicians providing adjuvant treatment if indicated. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS				
Specialty(s):	general surgery; otolaryngology				
CPT Code:	21557				
Sample Size:	75	**Resp N:**	30	**Response:** 40.0 %	
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:	11.00	12.00	**15.00**	23.18	26.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**113.00**	139.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21557	**Recommended Physician Work RVU: 14.57**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**113.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38700	090	12.68	**RUC Time**

CPT Descriptor Suprahyoid lymphadenectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	**CPT Code: 21557**	**Key Reference CPT Code: 38700**	**Source of Time RUC Time**
Median Pre-Service Time	72.00	60.00	
Median Intra-Service Time	113.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**398.00**	**300.00**	
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	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.80
Urgency of medical decision making	3.60	3.40

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.20
Physical effort required	4.00	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	3.80
Outcome depends on the skill and judgment of physician	4.20	4.00
Estimated risk of malpractice suit with poor outcome	3.20	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.80	3.80
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	3.40	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21557 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax), soft tissue of foot) will be deleted in 2010 and replaced by two new codes (P11 and P12). During the Harvard study, 11 general surgeons were surveyed. Otolaryngology was not involved. No positioning work was recorded. No positioning time was recorded. These patients are not typically Medicare-aged and will typically be admitted to the hospital. The Medicare database site of service distribution for this code does not reflect national distribution.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: No change
- Positioning: Add 9 minutes - After induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head rotated and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed..
- Scrub/Dress/Wait: No change

Recommendation: The survey data show - and our expert consensus panel concurs - that patients with deep sarcomas will typically be admitted to the hospital. The consensus committee recommends the survey median RVW *adjusted* down to 14.57 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.056. This RVW is greater than the reference code 38700, accounting fo more intra-operative time and complexity and more post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21557

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21558 Tracking Number P12 Specialty Society Recommended RVU: **21.37**

Global Period: 090 RUC Recommended RVU: **21.37**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old male presents with an 8 cm sarcoma near the sternocleidomastoid muscle in the neck. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 4% , Admitted (more than 24 hours) 96%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head rotated and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed. 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, an incision is made along the sternocleidomastoid muscle encompassing the overlying skin from the biopsy site. Subplatysmal flaps are raised. The tumor, attached to the sternocleidomastoid muscle, is isolated. Medially and superiorly, the internal jugular vein, carotid artery and vagus nerve are identified and retracted toward the midline. Laterally and posteriorly, the spinal accessory nerve is identified within the posterior triangle, and dissected free of the sternocleidomastoid muscle anteriorly to the internal jugular ve preserving the nerve. Transection of the superior aspect of the sternocleidomastoid muscle, already partially transected by following the spinal accessory nerve, is completed with a wide margin around the tumor. Inferior to the tumor, the sternocleidomastoid muscle is likewise transected with a wide margin, separating the muscle from the internal jugular vein and omohyoid muscle. The deep aspect of the tumor and sternocleidomastoid muscle are then dissected free of the fascia investing the deep neck musculature and brachial plexus, taking care not to traumatize these structures, taking a

margin of fibrofatty tissue The specimen is sent to pathology for frozen and permanent sections. The specimen is oriented for the pathologist, with direct communication between the surgeon and pathologist to ensure accurate pathologic interpretation. Frozen sections are taken from the surrounding tissue as indicated. Additional excision is carried out if necessary to obtain a clear margin. Often, removal of the internal jugular vein, spinal accessory nerve, or other neurovascular structures is required to obtain clear margins. The wound is inspected and irrigated. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied to the neck. Discuss postoperative care with recovery room staff. Assess hemodynamic, cranial nerve and drain function. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including determination of hematocrit, oxygenation status, and airway patency. Write orders for transferring to ICU and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Discuss surgery outcome with patient. Perform an expanded problem focused exam, reassessing hemodynamic and airway status, cranial nerve, and drain function. Wound care and close observation are important to avoid or promptly treat wound hematoma. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drains when appropriate. Discuss pathology report with the patient and family, as well as, recommendations for further evaluation, treatment, and monitoring as appropriate. Communicate with other physicians providing adjuvant treatment if indicated. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and letermine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS				
Specialty(s):	general surgery; otolaryngology				
CPT Code:	21558				
Sample Size:	75	**Resp N:**	30	**Response:** 40.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**1.00**	3.00	25.00
Survey RVW:	15.00	20.00	**22.00**	25.70	30.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	90.00	120.00	**160.00**	180.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21558	**Recommended Physician Work RVU: 21.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15734	090	19.62	**RUC Time**

CPT Descriptor Muscle, myocutaneous, or fasciocutaneous flap; trunk

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 36.6 %

TIME ESTIMATES (Median)

	CPT Code: 21558	**Key Reference CPT Code:** 15734	**Source of Time** RUC Time
Median Pre-Service Time	72.00	60.00	
Median Intra-Service Time	160.00	163.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	115.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	118.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**502.00**	**524.00**	
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	4.70	4.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.20
Urgency of medical decision making	4.20	4.10

Technical Skill/Physical Effort (Mean)

Technical skill required	4.70	4.20
Physical effort required	4.00	3.90

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.10	3.90
Outcome depends on the skill and judgment of physician	4.70	4.30
Estimated risk of malpractice suit with poor outcome	4.60	4.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.50	4.30
Intra-Service intensity/complexity	4.30	4.00
Post-Service intensity/complexity	4.10	4.10

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21557 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax), soft tissue of foot) will be deleted in 2010 and replaced by two new codes (P11 and P12). During the Harvard study, 11 general surgeons were surveyed. Otolaryngology was not involved. No positioning work was recorded. No positioning time was recorded. These patients are not typically Medicare-aged and will typically be admitted to the hospital. The Medicare database site of service distribution for this code does not reflect national distribution.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change.
- Positioning: Add 9 minutes - After induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head rotated and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed.
- Scrub/Dress/Wait: no change

Recommendation: The survey data show - and our expert consensus panel concurs - that patients with deep sarcomas will typically be admitted to the hospital. The consensus committee recommends the survey median RVW *adjusted* down to 21.37 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit nformation, this results in an IWPUT of 0.068. This RVW is greater than the reference code 15734, accounting for greater intra-operative complexity and intensity and additional facility work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21557

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21935 Tracking Number P17 Specialty Society Recommended RVU: **15.54**

Global Period: 090 RUC Recommended RVU: **15.54**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with a 4 cm sarcoma in the trapezius on the back. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 5% , Kept overnight (less than 24 hours) 22% , Admitted (more than 24 hours) 73%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of x-ray, CT, MRI, MRA. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. 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, an incision is made over the trapezius. Medial and lateral subcutaneous flaps are raised. The overlying skin from the biopsy is excised with the tumor. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. The dissection removes a large portion of the trapezius including the fascia of the deep paraspinal muscles below it. The tumor is removed en bloc, including necessary surrounding structures. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Frozen sections are taken from the surrounding tissue. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs is carried out. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the

surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. Metallic clips are placed to mark the margins for possible postoperative radiotherapy guidance. T wound is inspected and irrigated. Devitalized muscle is debrided. A deep drain is placed. The wound is closed layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings and soft brace. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	21935					
Sample Size:	100	**Resp N:**	41	**Response:** 41.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	3.00	10.00
Survey RVW:		13.00	15.00	**16.00**	21.50	31.00
Pre-Service Evaluation Time:				**60.00**		
Pre-Service Positioning Time:				**20.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		60.00	90.00	**120.00**	120.00	180.00
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21935	**Recommended Physician Work RVU: 15.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		
Immediate Post Service-Time:	**25.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
27880	090	15.24	**RUC Time**

CPT Descriptor Amputation, leg, through 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 19.5 %

TIME ESTIMATES (Median)	CPT Code: 21935	Key Reference CPT Code: 27880	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	120.00	80.00	
Median Immediate Post-service Time	25.00	20.00	
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	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**408.00**	**400.00**	
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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.13
Urgency of medical decision making	4.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.25
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.13
Outcome depends on the skill and judgment of physician	4.13	3.13
Estimated risk of malpractice suit with poor outcome	3.88	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.50	2.63
Intra-Service intensity/complexity	3.75	3.13
Post-Service intensity/complexity	2.88	2.63

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21935 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank) will be deleted in 2010 and replaced by two new codes (P17 and P18). During the Harvard study, 12 general surgeons were surveyed only for intra-operative time. Pre and post times were predicted. The Harvard study intra-time is less than the RUC survey intra-time for both P17 and P18. These patients are not typically Medicare-aged and will typically be admitted to the hospital for resection of these deep malignant tumors.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 15.54 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.057. This is similar to the IWPUT for the reference code 27880, which has less intra-operative time and similar total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 21935

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21936 Tracking Number P18 Specialty Society Recommended RVU: **22.34**

Global Period: 090 RUC Recommended RVU: **22.34**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with a 10 cm sarcoma in the trapezius and paraspinal muscles. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 2% , Admitted (more than 24 hours) 98%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. 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, an incision is made over the trapezius. Medial and lateral subcutaneous flaps are raised. The overlying skin from the biopsy is excised with the tumor. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. The dissection removes a large portion of the trapezius including the fascia of the deep paraspinal muscles below it. The tumor is removed en bloc, including necessary surrounding structures. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Frozen sections are taken from the surrounding tissue. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs is carried out. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of

the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. Metallic clips are placed to mark the margins for possible postoperative radiotherapy guidance. The wound is inspected and irrigated. Devitalized muscle is debrided. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings and soft brace. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	21936				
Sample Size:	100	**Resp N:**	41	**Response:** 41.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	8.00
Survey RVW:	19.00	21.00	**23.00**	27.00	40.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	80.00	120.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21936	**Recommended Physician Work RVU: 22.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global		Work RVU	Time Source
49203	090	–	20.00	**RUC Time**

CPT Descriptor Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 24.3 %

TIME ESTIMATES (Median)	CPT Code: 21936	Key Reference CPT Code: 49203	Source of Time RUC Time
Median Pre-Service Time	80.00	70.00	
Median Intra-Service Time	160.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**510.00**	**420.00**	
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	4.70	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.10
Urgency of medical decision making	3.90	3.80

Technical Skill/Physical Effort (Mean)

Technical skill required	4.90	4.30
Physical effort required	4.10	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.30	4.00
Outcome depends on the skill and judgment of physician	4.90	4.40
Estimated risk of malpractice suit with poor outcome	4.70	4.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.60	4.00
Intra-Service intensity/complexity	4.60	4.10
Post-Service intensity/complexity	3.90	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21935 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank) will be deleted in 2010 and replaced by two new codes (P17 and P18). During the Harvard study, 12 general surgeons were surveyed only for intra-operative time. Pre and post times were predicted. The Harvard study intra-time is less than the RUC survey intra-time for both P17 and P18. These patients are not typically Medicare-aged and will typically be admitted to the hospital for resection of these deep malignant tumors.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically be admitted to the hospital. The consensus committee recommends the survey median RVW *adjusted* down to 22.34 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.073. This is less than the IWPUT for the reference code 49203, which has less intra-operative time and less total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 21935

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

)

CPT Code:23077 Tracking Number P29 Specialty Society Recommended RVU: **17.48**

Global Period: 090 RUC Recommended RVU: **17.48**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male presents with a 3 cm malignant fibrous histiocytoma in the right posterior deltoid muscle. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 23% , Admitted (more than 24 hours) 77%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. 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 7 incision is made over the posterior deltoid tumor, excising the old biopsy tract. Medial and lateral subcutaneous flaps are raised. The innervation of the deltoid is protected. Careful dissection is carried into the deltoid muscle staying in normal muscle. A radical excision of the posterior deltoid is made. The tumor is removed en bloc, including necessary surrounding structures preserving the axillary nerve. Frozen sections are taken from the surrounding tissue. The margins and tumor are sent to pathology. The pathology report is received and additional excision is carried out as necessary to obtain a clear margin. The wound is inspected and rigated. Hemostasis is obtained. A deep drain is placed. The deep tissue is closed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply dressings and shoulder immobilizer. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss

ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of shoulder immobilizer. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	23077					
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	6.00	25.00
Survey RVW:	12.00	16.00	**18.00**	22.00	30.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	90.00	**140.00**	150.00	270.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23077	**Recommended Physician Work RVU: 17.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**140.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
23395	090	18.29	RUC Time

CPT Descriptor Muscle transfer, any type, shoulder or upper arm; single

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 34.2 %

TIME ESTIMATES (Median)	CPT Code: 23077	Key Reference CPT Code: 23395	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	140.00	160.00	
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	85.0	115.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**433.00**	**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	4.33	3.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	3.83
Urgency of medical decision making	4.17	3.42

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.17
Physical effort required	3.83	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	4.00
Outcome depends on the skill and judgment of physician	4.50	4.08
Estimated risk of malpractice suit with poor outcome	3.83	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.17	3.75
Intra-Service intensity/complexity	4.25	3.83
Post-Service intensity/complexity	3.92	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 23077 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area) will be deleted in 2010 and replaced by two new codes (P29 and P30). During the Harvard study, 11 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. The current survey, which includes general surgeons results in different time and visit data.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 17.48 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.062. This is similar to the IWPUT for the reference code 23395, which represents similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23077

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.

,pecialty Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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?

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:23078 Tracking Number P30 Specialty Society Recommended RVU: **22.34**

Global Period: 090 RUC Recommended RVU: **22.34**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male presents with a 10 cm malignant fibrous histiocytoma in the right posterior deltoid muscle. At operation, a radical resection of the shoulder with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 6% , Admitted (more than 24 hours) 94%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. 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 14 incision is made over the posterior deltoid tumor, excising the old biopsy tract. Medial and lateral subcutaneous flaps are raised. The innervation of the deltoid is protected. The parascapular muscles are identified and protected. Careful dissection is carried into the deltoid muscle staying in normal muscle. A radical excision of the posterior deltoid is made. Subperiosteal dissection of the tumor off of the scapula is carried out. The tumor is removed en bloc, including necessary surrounding structures preserving the axillary nerve. Frozen sections are taken from the surrounding tissue. The margins and tumor are sent to pathology. The pathology report is received and additional excision is carried out as necessary to obtain a clear margin. The wound is inspect and irrigated. Hemostasis is obtained. A deep drain is placed. The deep tissue is closed with interrupted sutures. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply dressings and shoulder immobilizer. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After

patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient nd patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess eurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of shoulder immobilizer. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology		
CPT Code:	23078		
Sample Size:	100	**Resp N:** 35	**Response:** 35.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	8.00	25.00
Survey RVW:	17.00	21.00	**23.00**	25.50	45.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	90.00	120.00	**180.00**	180.00	350.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23078	**Recommended Physician Work RVU: 22.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 51.4 %

TIME ESTIMATES (Median)	CPT Code: 23078	Key Reference CPT Code: 23472	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	180.00	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	102.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**490.00**	**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	4.78	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	3.67
Urgency of medical decision making	4.56	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	4.28
Physical effort required	4.28	3.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	3.72
Outcome depends on the skill and judgment of physician	4.83	4.33
Estimated risk of malpractice suit with poor outcome	4.22	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.61	3.50
Intra-Service intensity/complexity	4.83	3.94
Post-Service intensity/complexity	4.39	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 23077 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area) will be deleted in 2010 and replaced by two new codes (P29 and P30). During the Harvard study, 11 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. The current survey, which includes general surgeons results in different time and visit data.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 22.34 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.072. This is similar to the IWPUT for the reference code 23472, which represents similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23077

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24077 Tracking Number P38 Specialty Society Recommended RVU: **15.54**

Global Period: 090 RUC Recommended RVU: **15.54**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male undergoes radical resection of a 3 cm liposarcoma of the medial triceps muscles of the arm.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 21% , Admitted (more than 24 hours) 79%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A volar longitudinal incision is made beginning at the elbow crease including an elliptical incision around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues contaminated by the initial biopsy. The deep fascia is incised longitudinally and again includes an ellipse around the biopsy track. Dissection proceeds in medial and lateral directions to form appropriate flaps and facilitate deep dissection. Perforating vessels are encountered and are ligated and incised. Proximally, the radial and ulnar arteries as well as the median and ulnar nerves are identified and dissection is carried adjacent to these structures to establish a plane of dissection which preserves them but remains in normal tissues outside of tumor. Several perforating vessels leading to the tumor are ligated and incised. In the proximal portion of the surgical field, the involved flexor muscles are exposed above the proximal extent of the tumor. These structures are then incised to establish a proximal margin well beyond tumor

extension. At this point the neuro-vascular structures are again identified. They are carefully dissected and separated from the adjacent tumor and intended plane of dissection. Several motor branches are seen to run into the tumor and can not be preserved so these branches are individually ligated and incised. Other motor branches are noted to bypass the tissues involved in the tumor and these are protected and preserved. Dissection is then carried along the medial lateral aspects of the tumor keeping normal tissue between the tumor and the plane of dissection. Several perforat vessels are again encountered and these are ligated and incised. Preoperative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neuro-vascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Further perforating vessels encountered and are ligated and incised. Further dissection is carried distally until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved flexor muscles are transected 2 cm from the furthest extent of tumor as determined by imaging studies and clinical impression. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The tourniquet is let down. Hemostasis is obtained and drains are left deep in the wound. A multilayered closure is performed.

Description of Post-Service Work: Apply dressings and shoulder immobilizer. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Asse neurovascular status. Wound care and close observation are important to avoid or promptly treat compartm syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of shoulder immobilizer. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology					
CPT Code:	24077					
Sample Size:	100	**Resp N:**	42	**Response:** 42.0 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**4.00**	5.00	25.00
Survey RVW:	13.00	16.00	**17.00**	20.75	28.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**120.00**	150.00	180.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	24077	**Recommended Physician Work RVU: 15.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
23395	090	18.29	**RUC Time**

CPT Descriptor Muscle transfer, any type, shoulder or upper arm; single

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 21.4 %

TIME ESTIMATES (Median)	CPT Code: 24077	Key Reference CPT Code: 23395	Source of Time RUC Time
Median Pre-Service Time	72.00	60.00	
Median Intra-Service Time	120.00	160.00	
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	85.0	115.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**405.00**	**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	4.56	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	3.67
Urgency of medical decision making	4.56	3.44

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	4.11
Physical effort required	3.78	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	3.67
Outcome depends on the skill and judgment of physician	4.67	4.11
Estimated risk of malpractice suit with poor outcome	4.22	3.78

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.56	3.56
Intra-Service intensity/complexity	4.00	3.56
Post-Service intensity/complexity	4.22	3.56

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 24077 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area) will be deleted in 2010 and replaced by two new codes (P38 and P39). During the Harvard study, 12 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 15.54 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.058. This is similar to the IWPUT for the reference code 23395, which has a higher RVW to account for additional intra-op time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 24077

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

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	4.89	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	3.67
Urgency of medical decision making	4.78	3.56

Technical Skill/Physical Effort (Mean)

Technical skill required	4.94	4.28
Physical effort required	4.56	4.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.89	4.17
Outcome depends on the skill and judgment of physician	4.89	4.17
Estimated risk of malpractice suit with poor outcome	4.83	4.06

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.72	3.94
Intra-Service intensity/complexity	4.83	4.33
Post-Service intensity/complexity	4.67	3.83

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 24077 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area) will be deleted in 2010 and replaced by two new codes (P38 and P39). During the Harvard study, 12 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 20.40 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.070. This is less than the IWPUT for the reference code 24363, which has the same intra-time and similar total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 24077

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25077 Tracking Number P46 Specialty Society Recommended RVU: **12.75**

Global Period: 090 RUC Recommended RVU: **12.75**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male presents with a 3 cm malignant fibrous histiocytoma of the flexor carpi radialis. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 28% , Kept overnight (less than 24 hours) 37% , Admitted (more than 24 hours) 35%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 76%

ıs moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review imaging, pathology and laboratory studies; with special attention to review of x-ray, CT, MRI, bone scan, PET scan and arteriograms, as well as consulting with radiology regarding margins. Communicate with plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on the upper arm. Prep and drape the arm. Scrub and gown. Perform surgical "time out" with operating surgical team. Elevate the arm and inflate the pneumatic tourniquet.

Description of Intra-Service Work: A volar longitudinal incision is made from the elbow crease to about 5 cm above the wrist including an elliptical incision around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues ɔntaminated by the initial biopsy. The deep fascia is then incised longitudinally and again includes an ellipse around the ɔiopsy track. Dissection is then carried in medial and lateral directions to form appropriate flaps and facilitate deep dissection. Perforating vessels are encountered and are ligated and incised. Proximally, the radial and ulnar arteries as well as the median and ulnar nerves are identified and dissection is carried adjacent to these structures to establish a plane of dissection which preserves them but remains in normal tissues outside of tumor. Several perforating vessels leading to the tumor are ligated and incised. In the proximal portion of the surgical field, the involved flexor muscles

are exposed above the proximal extent of the tumor. These structures are then incised to establish a proximal margin well beyond tumor extension. At this point the neuro-vascular structures are again identified. They are carefully dissected and separated from the adjacent tumor and intended plane of dissection. Several motor branches are seen to run into the tumor and can not be preserved so these branches are individually ligated and incised. Other m branches are noted to bypass the tissues involved in the tumor and these are protected and preserved. Dissection is t carried along the medial and lateral aspects of the tumor keeping normal tissue between the tumor and the plane of dissection. Several perforating vessels are again encountered and these are ligated and incised. Preoperative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neuro-vascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Further perforating vessels encountered and are ligated and incised. Further dissection is carried distally until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved flexor muscles are transected 2 cm from the furthest extent of tumor as determined by imaging studies and clinical impression. Cultures are taken. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The tourniquet is let down and hemostasis is obtained and drains are left deep in the wound. A multilayered closure is then performed.

Description of Post-Service Work: Apply soft dressing and splint to hold the wrist in neutral alignment. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentatio Later on the day of surgery, review medical records and interval data charted. Communicate with other professiona and with patient and patient's family. Perform an exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; orthopaedic surgery; general & orthopaedic surgical oncology; hand surgery; plastic surgery				
CPT Code:	25077				
Sample Size:	150	**Resp N:**	58	**Response:** 38.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	8.00
Survey RVW:	6.00	12.00	**14.25**	18.00	30.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	50.00	83.00	**100.00**	120.00	200.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	25077	**Recommended Physician Work RVU: 12.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
25515	090	9.89	**RUC Time**

CPT Descriptor Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 25.8 %

TIME ESTIMATES (Median)	CPT Code: 25077	Key Reference CPT Code: 25515	Source of Time RUC Time
Median Pre-Service Time	72.00	45.00	
Median Intra-Service Time	100.00	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	0.00	
Median Office Visit Time	85.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**345.00**	**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	4.15	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.77
Urgency of medical decision making	3.85	3.31

Technical Skill/Physical Effort (Mean)

Technical skill required	4.08	3.92
Physical effort required	3.46	3.46

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.15	3.85
Outcome depends on the skill and judgment of physician	4.23	3.92
Estimated risk of malpractice suit with poor outcome	4.08	3.77

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.92	3.62
Intra-Service intensity/complexity	4.00	3.77
Post-Service intensity/complexity	3.69	3.42

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 25077 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area) will be deleted in 2010 and replaced by two new codes (P46 and P47). During the Harvard study, 10 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends an RVW that is midway between the survey 25th percentile and median to place this code in correct rank order with the rest of the family of subfacial codes. Additionally, this value has been *adjusted* (decreased) to 12.75 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.055. This is greater than the IWPUT for the reference code 25515, and reflects the more demanding deep resection.

SERVICES REPORTED WITH MULTIPLE 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) 25077

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

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:25078 Tracking Number P47 Specialty Society Recommended RVU: **17.48**

Global Period: 090 RUC Recommended RVU: **17.48**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male presents with a 7 cm malignant fibrous histiocytoma of the flexor muscles of the mid-forearm. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 10% , Kept overnight (less than 24 hours) 29% , Admitted (more than 24 hours) 60%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 71%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review imaging, pathology and laboratory studies; with special attention to review of x-ray, CT, MRI, bone scan, PET scan and arteriograms, as well as consulting with radiology regarding margins. Communicate with plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on the upper arm. Prep and drape the arm. Scrub and gown. Perform surgical "time out" with operating surgical team. Elevate the arm and inflate the pneumatic tourniquet.

Description of Intra-Service Work: A volar longitudinal incision is made from the elbow crease to about 10 cm above the wrist including an elliptical incision around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues contaminated by the initial biopsy. The deep fascia is then incised longitudinally and again includes an ellipse around the biopsy track. Dissection is then carried in medial and lateral directions to form appropriate flaps and facilitate deep dissection. Perforating vessels are encountered and are ligated and incised. Proximally, the radial and ulnar arteries as well as the median and ulnar nerves are identified and dissection is carried adjacent to these structures to establish a plane of dissection which preserves them but remains in normal tissues outside of tumor. Several perforating vessels leading to the tumor are ligated and incised. In the proximal portion of the surgical field, the involved flexor

muscles are exposed above the proximal extent of the tumor. These structures are then incised to establish a proximal margin well beyond tumor extension. At this point the neuro-vascular structures are again identified. They are carefully dissected and separated from the adjacent tumor and intended plane of dissection. Several motor branches are seen to run into the tumor and can not be preserved so these branches are individually ligated and incised. Other motor branches are noted to bypass the tissues involved in the tumor and these are protected and preserved. Dissection is then carried along the medial and lateral aspects of the tumor keeping normal tissue between the tumor and the plane of dissection. Several perforating vessels are again encountered and these are ligated and incised. Preoperative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neuro-vascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Further perforating vessels encountered and are ligated and incised. Further dissection is carried distally until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved flexor muscles are transected 2 cm from the furthest extent of tumor as determined by imaging studies and clinical impression. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The tourniquet is let down and hemostasis is obtained and drains are left deep in the wound. A multilayered closure is then performed.

Description of Post-Service Work: Apply soft dressing and splint to hold the wrist in neutral alignment. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management reconstruction. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS					
Specialty(s):	general surgery; orthopaedic surgery; general & orthopaedic surgical oncology; hand surgery; plastic surgery					
CPT Code:	25078					
Sample Size:	150	**Resp N:**	58	**Response:** 38.6 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	3.00	7.00
Survey RVW:	8.50	14.22	**18.00**	22.00	30.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**120.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	25078	**Recommended Physician Work RVU: 17.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24363	090	22.47	**RUC Time**

CPT Descriptor Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 41.3 %

TIME ESTIMATES (Median)	**CPT Code: 25078**	**Key Reference CPT Code: 24363**	**Source of Time RUC Time**
Median Pre-Service Time	72.00	83.00	
Median Intra-Service Time	120.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**422.00**	**466.00**	
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	4.77	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.82	3.82
Urgency of medical decision making	4.68	3.55

Technical Skill/Physical Effort (Mean)

Technical skill required	4.91	4.55
Physical effort required	4.55	4.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.86	4.18
Outcome depends on the skill and judgment of physician	4.82	4.36
Estimated risk of malpractice suit with poor outcome	4.73	4.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.82	4.09
Intra-Service intensity/complexity	4.86	4.41
Post-Service intensity/complexity	4.64	4.14

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 25077 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area) will be deleted in 2010 and replaced by two new codes (P46 and P47). During the Harvard study, 10 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 17.48 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.070. This is less than the IWPUT for the reference code 24363. The RVW reflects less intra-op time and total work compared with 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) 25077

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 25025

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:26117 Tracking Number P53 Specialty Society Recommended RVU: **9.95**

Global Period: 090 RUC Recommended RVU: **9.95**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male presents with a 2 cm epithelioid sarcoma in the abductor pollicis brevis. At operation, the tumor and adjacent soft tissue are excised.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 52% , Kept overnight (less than 24 hours) 33% , Admitted (more than 24 hours) 14%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 71%

s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made excising the old biopsy tract. Medial and lateral skin flaps are raised. The tumor is removed en bloc, including necessary surrounding structures. Frozen sections are taken from the surrounding tissue. The margins and tumor are sent to pathology. Additional excision is carried out as necessary to obtain a clear margin. The tourniquet is released and meticulous hemostasis is achieved using a bipolar electrocautery. The wound is inspected and irrigated. The wound is closed.

Description of Post-Service Work: Apply soft dressing and splint to hold the wrist in neutral alignment. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery

outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary c or referring physician of discharge plans. All appropriate medical records are completed, including discharge summa and discharge instructions, and insurance forms. The patient will be examined in the office within one or two days and for several more visits through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures and drain; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational therapy and assess functional recovery are carefully monitored. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS					
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; hand surgery; plastic surgery					
CPT Code:	26117					
Sample Size:	120	**Resp N:**	64	**Response:** 53.3 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**1.00**	4.00	10.00
Survey RVW:		2.40	8.30	**10.25**	14.03	25.00
Pre-Service Evaluation Time:				**50.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**20.00**		
Intra-Service Time:		40.00	60.00	**75.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	26117	**Recommended Physician Work RVU: 9.95**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**75.00**		
Immediate Post Service-Time:	**20.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**		
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
25447	090	10.95	**RUC Time**

CPT Descriptor Arthroplasty, interposition, intercarpal or carpometacarpal joints

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 12.5 %

TIME ESTIMATES (Median)	CPT Code: 26117	Key Reference CPT Code: 25447	Source of Time RUC Time
Median Pre-Service Time	72.00	45.00	
Median Intra-Service Time	75.00	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	85.0	94.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**271.00**	**278.00**	
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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.38	3.13
Urgency of medical decision making	4.13	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.38	3.75
Physical effort required	3.75	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.25
Outcome depends on the skill and judgment of physician	4.13	3.50
Estimated risk of malpractice suit with poor outcome	4.25	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	2.63
Intra-Service intensity/complexity	4.25	3.38
Post-Service intensity/complexity	3.50	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 26117 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger) will be deleted in 2010 and replaced by two new codes (P53 and P54). During the Harvard study, 12 orthopaedic surgeons were surveyed. Hand surgery and plastic surgery were not included in the review. Pre and post times were predicted. No positioning time was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 9.95 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.058. This is similar to the IWPUT for the reference code 25447. The RVW reflects less intra-op time and but more total work compared with 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) 26117

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26118 Tracking Number P54 Specialty Society Recommended RVU: **14.57**

Global Period: 090 RUC Recommended RVU: **14.57**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; 3 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male presents with a 4 cm epithelioid sarcoma in the abductor pollicis brevis and flexor pollicis brevis. At operation, the tumor and adjacent soft tissue are excised.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 30% , Kept overnight (less than 24 hours) 38% , Admitted (more than 24 hours) 33%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 88%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made excising the old biopsy tract. Medial and lateral skin flaps are raised. The tumor is removed en bloc, including necessary surrounding structures. Frozen sections are taken from the surrounding tissue. The margins and tumor are sent to pathology. Additional excision is carried out as necessary to obtain a clear margin. The tourniquet is released and meticulous hemostasis is achieved using a bipolar electrocautery. The wound is inspected and irrigated. The wound is closed.

Description of Post-Service Work: Apply soft dressing and splint to hold the wrist in neutral alignment. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses, especially monitoring for inflammation and neurovascular status. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical

records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office the next day and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD, FACS; Martha Matthews, MD, FACS					
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; hand surgery; plastic surgery					
CPT Code:	26118					
Sample Size:	120	**Resp N:**	64	**Response:** 53.3 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	2.00	5.00
Survey RVW:	5.10	10.38	**15.00**	21.00	30.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**100.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**118.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	26118	**Recommended Physician Work RVU: 14.57**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**118.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24363	090	22.47	**RUC Time**

CPT Descriptor Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)	**CPT Code: 26118**	**Key Reference CPT Code:** 24363	**Source of Time** RUC Time
Median Pre-Service Time	72.00	83.00	
Median Intra-Service Time	100.00	150.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	118.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**368.00**	**466.00**	
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	4.81	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.81	4.00
Urgency of medical decision making	4.75	3.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.69
Physical effort required	4.44	4.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.81	4.38
Outcome depends on the skill and judgment of physician	4.81	4.50
Estimated risk of malpractice suit with poor outcome	4.81	4.32

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.88	4.00
Intra-Service intensity/complexity	4.94	4.50
Post-Service intensity/complexity	4.69	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 26117 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger) will be deleted in 2010 and replaced by two new codes (P53 and P54). During the Harvard study, 12 orthopaedic surgeons were surveyed. Hand surgery and plastic surgery were not included in the review. Pre and post times were predicted. No positioning time was recorded.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome – the hand typically swells extensively after this procedure. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 14.57 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.066. This is less than the IWPUT for the reference code 24363. The RVW reflects less intra-op time and total work compared with 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) 26117

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 29807

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:27049 Tracking Number P62 Specialty Society Recommended RVU: **21.37**

Global Period: 090 RUC Recommended RVU: **21.37**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with a deep 4 cm malignant fibrous histiocytoma of the adductor muscles of the proximal thigh. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 97%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation meds. Verify that all required instruments and supplies are available. Patient is placed in supine position. 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 trapezius. Medial and lateral subcutaneous flaps are raised. The overlying skin from the biopsy is excised with the tumor. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. A radical excision of the adductor longus and superficial adductor brevis is performed. The tumor is removed en bloc, including necessary surrounding structures. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs and/or peritoneum is carried out. The surgeon then breaks scrub nd carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. Additional excision is

carried out as necessary to obtain a clear margin. Metallic clips are placed to mark the margins for possible postoperative radiotherapy guidance. The wound is inspected and irrigated. Devitalized muscle is debrided. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room sta Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology
CPT Code:	27049
Sample Size: 100	**Resp N:** 35 — **Response:** 35.0 %
Sample Type:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	10.00	35.00
Survey RVW:	16.00	20.00	**22.00**	25.00	35.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	133.00	**180.00**	180.00	300.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27049	**Recommended Physician Work RVU: 21.37**

	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:	**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:	**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**20.00**	**20.00**	**0.00**
Intra-Service Time:	**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
47380	090	24.43	**RUC Time**

CPT Descriptor Ablation, open, of one or more liver tumor(s); radiofrequency

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 22.8 %

TIME ESTIMATES (Median)	CPT Code: 27049	Key Reference CPT Code: 47380	Source of Time RUC Time
Median Pre-Service Time	63.00	85.00	
Median Intra-Service Time	180.00	200.00	
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	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**496.00**	**550.00**	
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	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	4.00
Urgency of medical decision making	3.63	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.38	4.25
Physical effort required	4.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.88
Outcome depends on the skill and judgment of physician	4.63	4.38
Estimated risk of malpractice suit with poor outcome	4.25	4.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.63	3.63
Intra-Service intensity/complexity	4.00	3.75
Post-Service intensity/complexity	3.13	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27049 (Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm)) will be deleted in 2010 and replaced by two new codes (P62 and P63). During the Harvard study, 8 orthopaedic surgeons were surveyed. Pre and post times were predicted. General surgeons and surgical oncologists, the primary providers were not surveyed. No positioning time was recorded. In 1995, an orthopaedic survey was rejected by the RUC for lack of compelling evidence. However, the failed survey times and visits were maintained in the RUC database. The IWPUT for the current RVW and RUC database times is 0.025, exceptionally low for a deep malignant tumor in the pelvis or hip.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

- Pre-Time: With respect to the pre-service time, we recommend package 4 with no changes.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 21.37 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.064. This is similar to the IWPUT for the reference code 47380, which involves similar intra-operative work/intensity. The RVW is less than the reference code, reflecting the slightly less intra-op time and differences in post hospital and office work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27049

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27059 Tracking Number P63 Specialty Society Recommended RVU: **29.14**

Global Period: 090 RUC Recommended RVU: **29.14**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with a deep 9 cm malignant fibrous histiocytoma of the adductor muscles of the proximal thigh. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation meds. Verify that all required instruments and supplies are available. Patient is placed in supine position. 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, an incision is made over the trapezius. Medial and lateral subcutaneous flaps are raised. The overlying skin from the biopsy is excised with the tumor. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. A radical excision of the adductor longus adductor brevis and a portion of the adductor magnus are performed. .The tumor is removed en bloc, including necessary surrounding structures. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Frozen sections are taken from the surrounding tissue. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs and/or peritoneum is carried out. The surgeon then breaks scrub and carr the specimen to the pathology department while the anesthesiologist and other operative personnel remain with th patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the

OR, repeats pre-operative scrub and returns to the surgical field. Additional excision is carried out as necessary to obtain a clear margin. Metallic clips are placed to mark the margins for possible postoperative radiotherapy guidance. The wound is inspected and irrigated. Devitalized muscle is debrided. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	27059				
Sample Size:	100	**Resp N:**	35	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	65.00
Survey RVW:	21.00	26.22	**30.00**	31.00	40.00
Pre-Service Evaluation Time:			**75.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	90.00	180.00	**220.00**	240.00	400.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **3.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27059	**Recommended Physician Work RVU: 29.14**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**220.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**140.00**	99231x **3.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 48.5 %

TIME ESTIMATES (Median)	**CPT Code: 27059**	**Key Reference CPT Code: 27134**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	90.00	
Median Intra-Service Time	220.00	240.00	
Median Immediate Post-service Time	45.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	140.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**608.00**	**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	4.82	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.88	4.00
Urgency of medical decision making	4.59	3.76

Technical Skill/Physical Effort (Mean)

Technical skill required	4.97	4.65
Physical effort required	4.53	4.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.88	4.29
Outcome depends on the skill and judgment of physician	4.88	4.59
Estimated risk of malpractice suit with poor outcome	4.71	4.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.59	4.24
Intra-Service intensity/complexity	4.82	4.59
Post-Service intensity/complexity	4.65	4.12

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27049 (Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm)) will be deleted in 2010 and replaced by two new codes (P62 and P63). During the Harvard study, 8 orthopaedic surgeons were surveyed. Pre and post times were predicted. General surgeons and surgical oncologists, the primary providers were not surveyed. No positioning time was recorded. In 1995, an orthopaedic survey was rejected by the RUC for lack of compelling evidence. However, the failed survey times and visits were maintained in the RUC database. The IWPUT for the current RVW and RUC database times is 0.025, exceptionally low for a deep malignant tumor in the pelvis or hip.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

- Pre-Time: With respect to the pre-service time, we recommend package 4 with no changes

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 29.14 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.077. This is slightly greater than the IWPUT for the reference code 27134, which involves similar intra-operative time and similar total work/intensity. This procedure is the most difficult and most intense of all the soft tissue tumor resection codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27049

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27329 Tracking Number P72 Specialty Society Recommended RVU: **15.54**

Global Period: 090 RUC Recommended RVU: **15.54**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with a 3 cm deep malignant fibrous histiocytoma of the hamstring muscles of the mid-posterior thigh. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 12% , Admitted (more than 24 hours) 88%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 80%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the upper thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 7 cm incision is made over the medial hamstrings. Medial and lateral subcutaneous flaps are made. Dissection is carried through the fascia into the semimembranosus muscle. The gracilis and semitendinosus are mobilized and retracted. The sciatic nerve is identified and protected. The semimembranosus muscle is dissected and the tumor is removed en bloc, including necessary surrounding normal tissue. Frozen sections are taken from the surrounding tissue. The margins and tumor are sent to pathology. The pathology report is received and additional excision is carried out as necessary to obtain a clear margin. Careful hemostasis is obtained. The wound is inspected and irrigated. The sciatic nerve is inspected. A deep drain is placed. The deep fascia is closed with interrupted sutures. The superficial wound is closed in layers with interrupted sutures.

Description of Post-Service Work: A compressive dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the leg to prevent hematoma formation. A knee immobilizer is applied. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history

and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within two to 3 days and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery				
CPT Code:	27329				
Sample Size:	120	**Resp N:**	42	**Response:** 35.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	15.00	40.00
Survey RVW:	14.00	18.00	**22.25**	25.00	40.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27329	**Recommended Physician Work RVU: 15.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 26.1 %

TIME ESTIMATES (Median)	CPT Code: 27329	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	80.00	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	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**413.00**	**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	4.89	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.89	2.78
Urgency of medical decision making	5.00	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	3.67
Physical effort required	4.11	3.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.89	4.00
Outcome depends on the skill and judgment of physician	4.89	3.89
Estimated risk of malpractice suit with poor outcome	4.78	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.89	3.33
Intra-Service intensity/complexity	4.67	3.56
Post-Service intensity/complexity	4.67	3.56

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27329 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area) will be deleted in 2010 and replaced by two new codes (P72 and P73). During the Harvard study, 9 orthopaedic surgeons were surveyed. Pre and post times were predicted. No positioning time was recorded. Subsequent to the Harvard study, 27329 were submitted by AAOS for review during the first 5-year-review. The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate the intra-operative work. Total work, intra-operative intensity, and levels of hospital and office visits were not considered.. New work values were calculated by adding an additional RVU increment to account for the different in intra-operative time between the Harvard study and the RUC survey. The IWPUT for the current RVW and RUC database times is 0.038, exceptionally low for a deep malignant tumor in the thigh or knee.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The survey median and 25th percentile result in an IWPUT that is inconsistent with the recommendations for the other small radical soft tissue tumor codes. The consensus committee recommends an RVW that is below the survey 25th percentile to place this code in correct rank order with the rest of the family of subfacial codes. Additionally, this value has been *adjusted* (decreased) to 15.54 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). This RVW ranks this code correctly relative to other small radical resection codes that have the same intra-op time and similar total time and work. Along with the recommended time and visit information, this results in an IWPUT of 0.056. This is less than the IWPUT for the reference code 27447, which involves similar intra-operative time but is more demanding intra-operatively compared with the radical resection of smaller deep tumors.

SERVICES REPORTED WITH MULTIPLE 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) 27329

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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? No

If no, please select another crosswalk and provide a brief rationale. 27329

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:27364 Tracking Number P73 Specialty Society Recommended RVU: **24.28**

Global Period: 090 RUC Recommended RVU: **24.28**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with an 8 cm deep malignant fibrous histiocytoma of the hamstring muscles of the mid-posterior thigh. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the upper thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a 12 cm incision is made over the medial hamstrings. Medial and lateral subcutaneous flaps are made. Dissection is carried through the fascia into the semimembranosus muscle. The gracilis and semitendinosus are mobilized and retracted. The sciatic nerve is identified and protected. The semimembranosus muscle is dissected and the large tumor is removed en bloc, including necessary surrounding normal tissue. Frozen sections are taken from the surrounding tissue. The margins and tumor are sent to pathology. The pathology report is received and additional excision is carried out as necessary to obtain a clear margin. Careful hemostasis is obtained. The wound is inspected and irrigated. The sciatic nerve is inspected. A deep drain is placed. The deep fascia is closed with interrupted sutures. The superficial wound is closed in layers with interrupted sutures.

Description of Post-Service Work: A compressive dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the leg to prevent hematoma formation. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also

shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within two to 3 days and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery		
CPT Code:	27364		
Sample Size:	120	**Resp N:** 42	**Response:** 35.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	**16.00**	25.00	50.00
Survey RVW:	18.00	23.00	**25.00**	30.00	50.00
Pre-Service Evaluation Time:			**70.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**18.00**		
Intra-Service Time:	90.00	126.00	**180.00**	195.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**120.00**	99231x **2.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27364	**Recommended Physician Work RVU: 24.28**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**120.00**	99231x **2.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

's 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

)ther Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 76.1 %

TIME ESTIMATES (Median)	CPT Code: 27364	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	80.00	75.00	
Median Intra-Service Time	180.00	124.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	120.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**550.00**	**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	4.93	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.93	3.22
Urgency of medical decision making	4.89	2.74

Technical Skill/Physical Effort (Mean)

Technical skill required	4.96	4.00
Physical effort required	4.68	3.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.93	3.74
Outcome depends on the skill and judgment of physician	4.93	3.93
Estimated risk of malpractice suit with poor outcome	4.71	3.70

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.89	3.70
Intra-Service intensity/complexity	4.89	3.96
Post-Service intensity/complexity	4.74	3.81

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27329 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area) will be deleted in 2010 and replaced by two new codes (P72 and P73). During the Harvard study, 9 orthopaedic surgeons were surveyed. Pre and post times were predicted. No positioning time was recorded. Subsequent to the Harvard study, 27329 were submitted by AAOS for review during the first 5-year-review. The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate the intra-operative work. Total work, intra-operative intensity, and levels of hospital and office visits were not considered.. New work values were calculated by adding an additional RVU increment to account for the different in intra-operative time between the Harvard study and the RUC survey. The IWPUT for the current RVW and RUC database times is 0.038, exceptionally low for a deep malignant tumor in the thigh or knee.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 24.28 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.071. This RVW is greater than the reference code and accounts for significantly more intra-operative time and more complex pre and post work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27329

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27615 Tracking Number P75 Specialty Society Recommended RVU: **15.54**

Global Period: 090 RUC Recommended RVU: **15.54**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents with a 3.5 cm deep fibrosarcoma of the soleus muscle of the superficial posterior compartment of the calf. At operation, the tumor and adjacent soft tissue are excised.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 6% , Kept overnight (less than 24 hours) 12% , Admitted (more than 24 hours) 82%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, an 8 cm posterior longitudinal incision is made around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues contaminated by the initial biopsy. The deep fascia is then incised longitudinally and again includes an ellipse around the biopsy track. Dissection is then carried in medial and lateral directions to form appropriate flaps and facilitate deep dissection. Perforating vessels are encountered and are ligated and incised. Proximally, the femoral vessels are identified and dissection is carried adjacent these structures to establish a plane of dissection. Several perforating branches leading to the tumor are ligated and ıcised. In the proximal portion of the surgical field, the involved calf muscles are exposed above the proximal extent of the tumor. Incision is carried across these structures to establish a proximal margin well beyond tumor extension. At this point the posterior tibial nerve and vascular bundle are identified. Several motor branches are seen to run into the tumor and can not be preserved so these branches are individually ligated and incised. Other motor branches are noted to bypass the tissues involved in the tumor and these are protected and preserved. Dissection is then carried along the

medial and lateral aspects of the tumor keeping normal tissue between the tumor and the plane of dissection. Preoperative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neuro-vascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Further dissection is carried dist until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved calf muscles transected 2 cm from the furthest extent of tumor as determined by imaging studies and clinical impression. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to pathology while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The wound is inspected and irrigated. A deep drain is placed. The wound is closed in layers with interrupted sutures. Careful monitoring of blood loss during the procedure is necessary with appropriate blood and fluid replacement.

Description of Post-Service Work: A compressive foot dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the leg to prevent hematoma formation. Apply splint. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within two to 3 days and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM					
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry					
CPT Code:	27615					
Sample Size:	150	**Resp N:**	49	**Response:** 32.6 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	1.00	1.00	**3.00**	5.00	40.00	
Survey RVW:	6.80	14.00	**16.00**	22.00	30.00	
Pre-Service Evaluation Time:			**55.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	45.00	90.00	**120.00**	150.00	180.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27615	**Recommended Physician Work RVU: 15.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**23.00**	**3.00**	**20.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		
Immediate Post Service-Time:	**30.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
27880	090	15.24	**RUC Time**

CPT Descriptor Amputation, leg, through 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 12.2 %

TIME ESTIMATES (Median)	CPT Code: 27615	Key Reference CPT Code: 27880	Source of Time RUC Time
Median Pre-Service Time	83.00	60.00	
Median Intra-Service Time	120.00	80.00	
Median Immediate Post-service Time	30.00	20.00	
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	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**416.00**	**400.00**	
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	4.33	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	3.50
Urgency of medical decision making	4.50	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	3.33
Physical effort required	3.17	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	3.33
Outcome depends on the skill and judgment of physician	4.67	3.67
Estimated risk of malpractice suit with poor outcome	4.17	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.17	3.17
Intra-Service intensity/complexity	4.33	3.17
Post-Service intensity/complexity	3.83	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27615 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area) will be deleted in 2010 and replaced by two new codes (P75 and P76). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. No positioning time was recorded. These patients are not typically Medicare-aged and will typically be admitted to the hospital. The Medicare database site of service distribution for this code does not reflect national distribution.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 20 minutes for prone positioning and application of a tourniquet
- Scrub/Dress/Wait: no change

Recommendation: Patients with deep fibrosarcomas will typically be admitted to the hospital. The consensus committee recommends the survey median RVW *adjusted* down to 15.54 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.055. This RVW is slightly greater than the reference code and accounts for significantly more intra-operative time balanced by less post work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27615

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27616 Tracking Number P76 Specialty Society Recommended RVU: **19.42**

Global Period: 090 RUC Recommended RVU: **19.42**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents with a 7.5 cm fibrosarcoma of the muscles of the posterior compartment of the calf. At operation, the tumor and adjacent soft tissue are excised.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 97%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Place tourniquet on the proximal thigh. Prep and drape leg. Elevate and exsanguinate leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a posterior longitudinal incision is made from the popliteal crease to about 10 cm above the ankle including an elliptical incision around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues contaminated by the initial biopsy. The deep fascia is then incised longitudinally and again includes an ellipse around the biopsy track. Dissection is then carried in medial and lateral directions to form appropriate flaps and facilitate deep dissection. Perforating vessels are encountered and are ligated and incised Proximally, the femoral vessels are identified and dissection is carried adjacent to these structures to establish a plane dissection. Several perforating branches leading to the tumor are ligated and incised. In the proximal portion of the surgical field, the involved calf muscles are exposed above the proximal extent of the tumor. Incision is carried across these structures to establish a proximal margin well beyond tumor extension. At this point the posterior tibial nerve and vascular bundle are identified. Several motor branches are seen to run into the tumor and can not be preserved so these branches are individually ligated and incised. Other motor branches are noted to bypass the tissues involved in the

tumor and these are protected and preserved. Dissection is then carried along the medial and lateral aspects of the tumor keeping normal tissue between the tumor and the plane of dissection. Preoperative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neuro-vascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Dissection is carried distally until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved calf muscles are transected 2 cm from the furthest extent of tumor as determined by imaging studies and clinical impression. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to pathology while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The wound is inspected and irrigated. A deep drain is placed. The wound is closed in layers with interrupted sutures. Careful monitoring of blood loss during the procedure is necessary with appropriate blood and fluid replacement.

Description of Post-Service Work: A compressive foot dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the leg to prevent hematoma formation. Apply splint. Transfer patient to the recovery room. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within two to 3 days and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for physical therapy. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry		
CPT Code:	27616		
Sample Size:	150	**Resp N:** 49	**Response:** 32.6 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	6.00	35.00
Survey RVW:	14.00	20.00	**22.40**	25.00	31.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	120.00	**150.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27616	**Recommended Physician Work RVU: 19.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**23.00**	**3.00**	**20.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**150.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
's 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

)ther Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 40.8 %

TIME ESTIMATES (Median)	CPT Code: 27616	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	83.00	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	102.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**463.00**	**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	4.94	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.94	3.28
Urgency of medical decision making	4.89	2.94

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	3.89
Physical effort required	4.50	3.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.89	3.61
Outcome depends on the skill and judgment of physician	4.94	4.00
Estimated risk of malpractice suit with poor outcome	4.61	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.94	3.50
Intra-Service intensity/complexity	5.00	3.89
Post-Service intensity/complexity	4.72	3.44

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 27615 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area) will be deleted in 2010 and replaced by two new codes (P75 and P76). During the Harvard study, 9 orthopaedic surgeons were surveyed. General surgery, the primary provider of this service, was not involved. Pre and post times were predicted. No positioning time was recorded. These patients are not typically Medicare-aged and will typically be admitted to the hospital. The Medicare database site of service distribution for this code does not reflect national distribution.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 20 minutes for prone positioning and application of a tourniquet
- Scrub/Dress/Wait: no change

Recommendation: Patients with deep fibrosarcomas will typically be admitted to the hospital. The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 19.42 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.067. This RVW is correctly less than the reference code 27447 and results in an IWPUT that is more consistent with the other large deep soft tissue tumor radical resection code recommendations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

   Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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 unlis code is reviewed) 27615

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialt
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28046 Tracking Number P84 Specialty Society Recommended RVU: **12.20**

Global Period: 090 RUC Recommended RVU: **12.20**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male presents with a 2 cm fibrosarcoma growing in the deep plantar space. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 8% , Kept overnight (less than 24 hours) 36% , Admitted (more than 24 hours) 61%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 64%

moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An elliptical incision is made on the sole of the foot around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues contaminated by the initial biopsy. The deep fascia is then incised longitudinally and again includes an ellipse around the biopsy track. Dissection is then carried in medial and lateral directions to form appropriate flaps and facilitate deep dissection. The lateral plantar nerve and artery are identified in the wound, as they come through the medial side of the foot. They are carefully dissected and separated from the adjacent tumor and intended plane of dissection. In the proximal portion of the surgical field, the involved muscles are posed above the proximal extent of the tumor. Dissection is then carried along the medial and lateral aspects of the umor, keeping normal tissue between the tumor and the plane of dissection. Pre-operative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neurovascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Further dissection is carried distally until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved intrinsic foot muscles are transected 2 cm from the furthest extent

of tumor as determined by imaging studies and clinical impression. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to pathology while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative f and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon th examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The wound is inspected and irrigated. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: A compressive foot dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the foot to prevent hematoma formation. Apply splint. Transfer patient to the recovery room. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform a problem focused exam, assessing open wound status and drain. Assess neurovascular status. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient neurovascular status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within 2 to 3 days for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropria Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physi therapy and assess functional recovery. Reconcile medication(s). Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	28046				
Sample Size:	120	**Resp N:**	48	**Response:** 40.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	10.00
Survey RVW:	7.53	12.56	**15.00**	48.25	30.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **2.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28046	**Recommended Physician Work RVU: 12.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **2.00** 99232x **0.00** 99233x **0.00**
scharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 10.4 %

TIME ESTIMATES (Median)	CPT Code: 28046	Key Reference CPT Code: 28299	Source of Time RUC Time
Median Pre-Service Time	56.00	75.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	25.00	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	**334.00**	**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	3.80	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.80
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	4.20
Physical effort required	3.50	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	3.80
Outcome depends on the skill and judgment of physician	4.20	4.20
Estimated risk of malpractice suit with poor outcome	4.00	3.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.80	3.60
Intra-Service intensity/complexity	3.80	3.80
Post-Service intensity/complexity	3.80	3.40

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 28046 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot) will be deleted in 2010 and replaced by two new codes (P84 and P85). During the Harvard study, 8 orthopaedic surgeons were surveyed. Podiatry, the primary provider of this service, was not involved. Pre and post times were predicted. No positioning time was recorded. These patients are not typically Medicare-aged and will typically be admitted to the hospital. The Medicare database site of service distribution for this code does not reflect national distribution.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: Patients with deep fibrosarcomas will typically be admitted to the hospital. The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 12.20 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.051. This RVW is slightly greater than the reference code 28299, accounting for the additional facility work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28046

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28047 Tracking Number P85 Specialty Society Recommended RVU: **17.24**

Global Period: 090 RUC Recommended RVU: **17.24**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; 3 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male presents with a 6 cm synovial sarcoma in the deep plantar space of the foot. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 14% , Kept overnight (less than 24 hours) 19% , Admitted (more than 24 hours) 67%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 43%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An elliptical incision is made on the sole of the foot around the previous biopsy track to keep this en bloc with the specimen. Dissection is then carried through the skin and subcutaneous tissues angling away from the biopsy track to avoid entering tissues contaminated by the initial biopsy. The deep fascia is then incised longitudinally and again includes an ellipse around the biopsy track. Dissection is then carried in medial and lateral directions to form appropriate flaps and facilitate deep dissection. The lateral plantar nerve and artery are identified in the wound, as they come through the medial side of the foot. They are carefully dissected and separated from the adjacent tumor and intended plane of dissection. In the proximal portion of the surgical field, the involved muscles are exposed above the proximal extent of the tumor. Dissection is then carried along the medial and lateral aspects of the tumor, keeping normal tissue between the tumor and the plane of dissection. Pre-operative imaging studies are reviewed during the procedure to verify intended planes of dissection and proximity to neurovascular structures. Once the tumor has been dissected laterally, medial dissection is then begun and the tumor and surrounding tissues are gently lifted from the wound from proximal to distal. Further perforating vessels are ligated and incised. Further dissection is carried distally until the circumferential dissection is beyond the distal extent of the tumor. At this point, the involved intrinsic

foot muscles are transected 6 cm from the furthest extent of tumor as determined by imaging studies and clinical impression. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to pathology while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. The wound is inspected and irrigated. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: A compressive foot dressing is applied in the operating room, the tourniquet is let down and compression is held for 10 minutes on the foot to prevent hematoma formation. Apply splint. Transfer patient to the recovery room. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings; assess wound and patient neurovascular status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of crutches or walker. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within 2 to 3 days for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Reconcile medication(s). Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM				
Specialty(s):	orthopaedic surgery; orthopaedic surgical oncology; foot and ankle orthopaedic surgery; podiatry				
CPT Code:	28047				
Sample Size: 120	**Resp N:** 48	**Response:** 40.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**2.00**	4.00	10.00
Survey RVW:	9.25	15.23	**17.75**	22.00	30.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	75.00	**120.00**	128.00	240.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	28047	**Recommended Physician Work RVU: 17.24**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
's 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

)ther Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.9 %

TIME ESTIMATES (Median)

	CPT Code: 28047	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	68.00	75.00	
Median Intra-Service Time	120.00	124.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
`Median Other Hospital Visit Time	60.0	100.00	
edian Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**413.00**	**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	4.78	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	3.00
Urgency of medical decision making	4.67	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	4.11
Physical effort required	4.33	3.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.56	3.56
Outcome depends on the skill and judgment of physician	4.78	4.00
Estimated risk of malpractice suit with poor outcome	4.89	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.63	3.63
Intra-Service intensity/complexity	5.00	4.13
Post-Service intensity/complexity	4.38	4.00

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 28046 (Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot) will be deleted in 2010 and replaced by two new codes (P84 and P85). During the Harvard study, 8 orthopaedic surgeons were surveyed. Podiatry, the primary provider of this service, was not involved. Pre and post times were predicted. No positioning time was recorded. These patients are not typically Medicare-aged and will typically be admitted to the hospital. The Medicare database site of service distribution for this code does not reflect national distribution.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: Patients with deep synovial or fibrosarcomas will typically be admitted to the hospital. The consensus committee recommends the survey median RVW *adjusted* down to 17.24 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.069. This RVW is less than the reference code 27447, accounting for less intra-operative complexity and less facility work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

   Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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 unli code is reviewed) 28046

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialt
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21011 Tracking Number P1 Specialty Society Recommended RVU: **2.91**

Global Period: 090 RUC Recommended RVU: **2.91**

CPT Descriptor: Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female undergoes excision of a 1.5 cm tumor on her scalp.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 44% , In the ASC 0%, In the office 56%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: After a separately reportable office visit E&M is performed, the decision to remove the lipoma from the scalp is made. Restate planned procedure and obtain informed consent. Verify that all required instruments and supplies are available in the treatment room. Position patient prone with head stabilized. Clip or part and secure scalp hair. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Inject local anesthesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue of the scalp. The tumor is identified and dissected free of surrounding structures and fascial attachments. The wound is inspected and irrigated. After assuring complete hemostasis, the wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a gauze dressing are applied, held in place with a head wrap bandage. The specimen is packaged to send to pathology, along with the appropriate history and information. Discuss surgery outcome with patient. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Write order for pain medication. Dictate operative report and complete medical record documentation. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; otolaryngology; plastic surgery				
CPT Code:	21011				
Sample Size: 120	**Resp N:** 43	**Response:** 35.8 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	7.00	**10.00**	20.00	150.00
Survey RVW:	1.70	2.50	**3.00**	4.13	7.50
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	20.00	**30.00**	33.00	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	21011	**Recommended Physician Work RVU: 2.91**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**22.00**	**17.00**	**5.00**
Pre-Service Positioning Time:		**6.00**	**1.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11642	010	2.57	**RUC Time**

CPT Descriptor Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 32.5 %

TIME ESTIMATES (Median)	**CPT Code: 21011**	**Key Reference CPT Code: 11642**	**Source of Time RUC Time**
Median Pre-Service Time	28.00	15.00	
Median Intra-Service Time	30.00	25.00	
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	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**107.00**	**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	2.14	2.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.07
Urgency of medical decision making	2.14	2.07

Technical Skill/Physical Effort (Mean)

Technical skill required	2.36	2.36
Physical effort required	2.07	2.07

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.29	2.29
Outcome depends on the skill and judgment of physician	2.43	2.50
Estimated risk of malpractice suit with poor outcome	2.43	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.07	2.00
Intra-Service intensity/complexity	2.07	2.14
Post-Service intensity/complexity	1.93	1.86

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.*

Currently, there is no CPT code for excision of a subcutaneous soft tissue tumor on the face or scalp. According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

Pre-Time: With respect to the pre-service time, we recommend package 6 with the following modifications:

- Evaluation: Add 5 minutes – moved from scrub/dress wait category because surgeon will administer local anesthesia.
- Positioning: Add 5 minutes to position patient prone with head stabilized and to clip, part and secure scalp hair.
- Scrub/Dress/Wait: Subtract 5 minutes – moved to evaluation category because surgeon will administer local anesthesia

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 2.91 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.023. The recommended RVW for this 90-day global code is greater than the reference code which is an office-based procedure with a 10-day global period and one post-op office visit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21012 Tracking Number P2 Specialty Society Recommended RVU: **4.37**

Global Period: 090 RUC Recommended RVU: **4.37**

CPT Descriptor: Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female undergoes excision of a 3.0 cm tumor on her forehead.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 84% , In the ASC 0%, In the office 16%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 94% , Kept overnight (less than 24 hours) 6% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with adjusting the OR table and MAC lines so that the operative site is assessable. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Infiltrate a local anesthetic to reduce postoperative pain.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue of the forehead overlying the mass, taking care to follow relaxed skin tension lines. The tumor is identified and dissected free of surrounding structures and fascial attachments. Dissection is carried out at the level of the tumor capsule, with meticulous technique to avoid injury to neurovascular structures, including branches of the facial nerve. Any such structures within the operative field are identified and preserved. The wound is inspected and irrigated. After assuring complete hemostasis, the wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied, held in place with a head wrap ndage. The specimen is sent to pathology, along with the appropriate history and information. Discuss postoperative are with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient and assess facial nerve function. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare

professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, ass wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and revi periodic lab and/or imaging, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; otolaryngology; plastic surgery				
CPT Code:	21012				
Sample Size:	120	**Resp N:**	43	**Response:** 35.8 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**9.00**	12.00	75.00
Survey RVW:	2.20	3.65	**4.50**	6.20	9.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	45.00	80.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	21012	**Recommended Physician Work RVU: 4.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**6.00**	**1.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11643	010	3.37	**RUC Time**

CPT Descriptor Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 27.9 %

TIME ESTIMATES (Median)	CPT Code: 21012	Key Reference CPT Code: 11643	Source of Time RUC Time
Median Pre-Service Time	30.00	30.00	
Median Intra-Service Time	45.00	30.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**148.00**	**93.00**	
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	2.27	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.09	2.55
Urgency of medical decision making	2.09	2.64

Technical Skill/Physical Effort (Mean)

Technical skill required	2.91	2.91
Physical effort required	2.36	2.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.64	2.64
Outcome depends on the skill and judgment of physician	2.82	2.73
Estimated risk of malpractice suit with poor outcome	2.82	2.64

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.36	2.64
Intra-Service intensity/complexity	2.64	2.55
Post-Service intensity/complexity	2.09	2.36

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.*

Currently, there is no CPT code for excision of a subcutaneous soft tissue tumor on the face or scalp. According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes - After induction of anesthesia in supine position, assist with adjusting the OR ta and MAC lines so that the operative site is assessable and the head is stabilized.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 4.37 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.032. This RVW is slightly greater than the reference code 11643, accounting for greater intra-time and the additional office visit within the 90-day global period for P2.

SERVICES REPORTED WITH MULTIPLE 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) According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21013 Tracking Number P3 Specialty Society Recommended RVU: **5.34**

Global Period: 090 RUC Recommended RVU: **5.34**

CPT Descriptor: Excision, tumor, soft tissue of face or scalp, subfascial (eg, intramuscular); less than 2 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female undergoes excision of a 1.5 cm submuscular tumor on her forehead.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 79% , In the ASC 0%, In the office 21%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 97% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and stabilize the head. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Infiltrate a local anesthetic to reduce postoperative pain.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue of the forehead overlying the mass, taking care to follow relaxed skin tension lines. The frontalis muscle is identified and incised. The tumor is identified and dissected free of surrounding structures and fascial attachments. Dissection is carried out at the level of the tumor capsule, with meticulous technique to avoid injury to neurovascular structures, including branches of the facial nerve. Any such structures within the operative field are identified and preserved. The wound is inspected and irrigated. After assuring complete hemostasis, the wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied, held in place with a head wra bandage. The specimen is sent to pathology, along with the appropriate history and information. Discuss postoperativ care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient and assess facial nerve function. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks

and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS; Martha Matthews, MD, FACS				
Specialty(s):	general surgery; otolaryngology; plastic surgery				
CPT Code:	21013				
Sample Size: 120	**Resp N:** 43	**Response:** 35.8 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**5.00**	11.00	30.00
Survey RVW:	2.00	4.38	**5.50**	6.66	11.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	21013	**Recommended Physician Work RVU: 5.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38510	010	6.69	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep cervical node(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 27.9 %

TIME ESTIMATES (Median)	CPT Code: 21013	Key Reference CPT Code: 38510	Source of Time RUC Time
Median Pre-Service Time	56.00	45.00	
Median Intra-Service Time	45.00	45.00	
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	19.00	
'edian Office Visit Time	39.0	23.00	
.olonged Services Time	0.0	0.00	
Median Total Time	**174.00**	**152.00**	
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	2.91	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.82
Urgency of medical decision making	2.64	2.91

Technical Skill/Physical Effort (Mean)

Technical skill required	3.27	3.18
Physical effort required	2.82	2.91

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.91	2.91
Outcome depends on the skill and judgment of physician	3.27	3.09
Estimated risk of malpractice suit with poor outcome	3.00	3.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.82	2.82
Intra-Service intensity/complexity	2.82	2.91
Post-Service intensity/complexity	2.45	2.55

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Currently, there is no CPT code for excision of a subfascial soft tissue tumor on the face or scalp. According to August 2000 CPT Assistant, when the lesions are located in deep subfascial or submuscular tissues, the appropriate code from the musculoskeletal system should be reported to describe the work entailed. However, there are no specific codes for excision of face/scalp or back/flank subfascial/intramuscular tumors. Unlisted codes 21499, 21899, 22899 or 20999 may have been reported.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes - After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable and stabilizing the head.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 5.34 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.043. This RVW is less than the reference code 38510 (even though P3 will have an additional office visit in the 90-day global period).

SERVICES REPORTED WITH MULTIPLE 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) According to August 2000 CPT Assistant, when the lesions are located in deep subfascial or submuscular tissues, the appropriate code from the musculoskeletal system should be reported to describe the work entailed. However, there are no specific codes for excision of face/scalp or back/flank subfascial/intramuscular tumors. Unlisted codes 21499, 21899, 22899 or 20999 may have been 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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21014 Tracking Number P4 Specialty Society Recommended RVU: **7.53**

Global Period: 090 RUC Recommended RVU: **7.00**

CPT Descriptor: Excision, tumor, soft tissue of face or scalp, subfascial (eg, intramuscular); 2 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male undergoes excision of a 6.5 cm tumor in the jaw musculature.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 0%, In the office 5%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 59% , Kept overnight (less than 24 hours) 39% , Admitted (more than 24 hours) 2%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 75%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Assure appropriate selection, timing, and administration of antibiotic bolus and anticoagulation meds. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and stabilize the head with access to the jaw. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Infiltrate a local anesthetic to reduce postoperative pain. A facial nerve monitor is positioned.

Description of Intra-Service Work: A curvilinear incision is made in relaxed skin tension creases anterior to the auricle, extending inferiorly and then anteriorly into the upper neck, three centimeters below and parallel to the lower edge of the mandible. A subplatysmal flap is elevated over the submandibular triangle, more superiorly at the level of the parotid fascia, to expose the submandibular and parotid glands. Peripheral branches of the facial nerve, including the buccal and marginal mandibular branches, are identified and preserved. The flap is further extended anteriorly over the masseter muscle. The muscle is split and the tumor is excised from within the masseter muscle. The wound is inspected ıd irrigated. After assuring complete hemostasis, a deep drain is placed, taking care to avoid contact with facial nerve ›ranches. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Steri-strips and a compression dressing are applied, held in place with a head wrap bandage. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen

and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient and assess facial nerve and jaw function. Monitor for hematoma formation and intraoral edema. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patie family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatm with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing), and special attention to chewing / using jaw muscle. Reconcile medications and write orders for home medications. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within 1-2 days and for several more visits through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove drain and sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Assess functional recovery and determine whether there is a need for speech/swallowing therapy. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; Jane Dillon, MD FACS; Martha Matthews, MD, FACS		
Specialty(s):	general surgery; otolaryngology; plastic surgery		
CPT Code:	21014		
Sample Size:	120	**Resp N:** 43	**Response:** 35.8 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**4.00**	8.00	25.00
Survey RVW:	3.20	6.00	**7.75**	10.00	15.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	45.00	**60.00**	75.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	21014	**Recommended Physician Work RVU: 7.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38510	010	6.69	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep cervical node(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 39.5 %

TIME ESTIMATES (Median)	CPT Code: 21014	Key Reference CPT Code: 38510	Source of Time RUC Time
Median Pre-Service Time	56.00	45.00	
Median Intra-Service Time	60.00	45.00	
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	62.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**217.00**	**152.00**	
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	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.40
Urgency of medical decision making	2.80	2.87

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.40
Physical effort required	3.27	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.27	3.27
Outcome depends on the skill and judgment of physician	3.67	3.53
Estimated risk of malpractice suit with poor outcome	3.47	3.47

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	3.13
Intra-Service intensity/complexity	3.53	3.33
Post-Service intensity/complexity	2.60	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.*

Currently, there is no CPT code for excision of a subfascial soft tissue tumor on the face or scalp. According to August 2000 CPT Assistant, when the lesions are located in deep subfascial or submuscular tissues, the appropriate code from the musculoskeletal system should be reported to describe the work entailed. However, there are no specific codes for excision of face/scalp or back/flank subfascial/intramuscular tumors. Unlisted codes 21499, 21899, 22899 or 20999 may have been reported.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes After induction of anesthesia in supine position, assist with adjusting the OR tabl and anesthesia lines so that the operative site is assessable and stabilizing the head.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 7.53 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.052. This RVW is greater than the reference code 38510, taking into account more intra-op time and more post-op visits.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) According to August 2000 CPT Assistant, when the lesions are located in deep subfascial or submuscular tissues, the appropriate code from the musculoskeletal system should be reported to describe the work entailed. However, there are no specific codes for excision of face/scalp or back/flank subfascial/intramuscular tumors. Unlisted codes 21499, 21899, 22899 or 20999 may have been 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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

.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:21932 Tracking Number P15 Specialty Society Recommended RVU: **9.71**

Global Period: 090 RUC Recommended RVU: **9.71**

CPT Descriptor: Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male undergoes excision of a 4 cm tumor in the paraspinal musculature of the back.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 44% , Kept overnight (less than 24 hours) 44% , Admitted (more than 24 hours) 12%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of spinal x-ray, CT, MRI, MRA. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery. The paraspinal muscle is exposed around the tumor. The tumor is excised along with surrounding muscle using electrocautery and dissection. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. Devitalized muscle is debrided. Where possible, the muscle fascial defect is approximated. A Penrose drain is placed in the cavitary defect. The wound is closed in layers with interrupt sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write

brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	21932				
Sample Size:	100	**Resp N:**	41	**Response:** 41.0 %	
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:	5.00	9.00	**10.00**	12.00	17.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	60.00	**75.00**	80.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38,, 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	21932	**Recommended Physician Work RVU: 9.71**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**55.00**	99211x **0.00** 12x **2.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
15100	090	9.74	**RUC Time**

CPT Descriptor Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 48.7 %

TIME ESTIMATES (Median)	**CPT Code: 21932**	**Key Reference CPT Code: 15100**	**Source of Time RUC Time**
Median Pre-Service Time	68.00	65.00	
Median Intra-Service Time	75.00	60.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**276.00**	**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	2.85	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.45
Urgency of medical decision making	2.65	2.55

Technical Skill/Physical Effort (Mean)

Technical skill required	3.30	2.80
Physical effort required	2.80	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.70	2.50
Outcome depends on the skill and judgment of physician	3.05	2.75
Estimated risk of malpractice suit with poor outcome	3.00	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.65	2.40
Intra-Service intensity/complexity	2.75	2.55
Post-Service intensity/complexity	2.15	2.10

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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21930 (Excision, tumor, soft tissue of back or flank) will be deleted in 2010 and replaced by four new codes (P13, P14, P15, and P16). During the Harvard study, 12 general surgeons were surveyed only for intra-operative time. Pre and post times were predicted. This prediction resulted in no positioning time, no facility post-work (even though the code is typically performed in a facility), and one office visit (even though the procedure will typically require at least two office visits during the 90-day global period). The prediction also placed the details for this code similar to the smallest subcutaneous excision details per the current survey (P13). The time and visit information for 21930 does not represent larger and/or deeper tumors. Further, without requiring a RUC survey in 1995 during the first 5-year-review, the code was reduced based on a comment letter.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 9.71 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.055. This is similar to the IWPUT for the reference code 15100, which has less intra-operative time, but the same total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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.

REQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21930

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21933 Tracking Number P16 Specialty Society Recommended RVU: **12.63**

Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male undergoes excision of a 7 cm tumor in the flank musculature of the back.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 7% , Kept overnight (less than 24 hours) 59% , Admitted (more than 24 hours) 34%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 83%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of spinal x-ray, CT, MRI, MRA. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. The tumor is excised along with surrounding muscle using electrocautery and dissection. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs is carried out. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. Devitalized muscle is debrided. Where possible, the muscle fascial defect is approximated. A Penrose drain is placed in the cavitary defect. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings and soft brace. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, includ neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a week and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order physical therapy and assess functional recovery. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD					
Specialty(s):	general surgery; orthopaedic surgery; orthopaedic and surgical oncology					
CPT Code:	21933					
Sample Size:	100	**Resp N:**	41	**Response:** 41.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**2.00**	5.00	8.00
Survey RVW:		6.60	12.00	**13.00**	15.00	20.00
Pre-Service Evaluation Time:				**45.00**		
Pre-Service Positioning Time:				**20.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		45.00	60.00	**90.00**	100.00	180.00
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	21933	**Recommended Physician Work RVU: 12.63**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38745	090	13.71	**RUC Time**

CPT Descriptor Axillary lymphadenectomy; complete

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 24.3 %

TIME ESTIMATES (Median)	CPT Code: 21933	Key Reference CPT Code: 38745	Source of Time RUC Time
Median Pre-Service Time	80.00	58.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	25.00	25.00	
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	62.0	79.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**315.00**	**271.00**	
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	3.82	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.64
Urgency of medical decision making	3.45	3.27

Technical Skill/Physical Effort (Mean)

Technical skill required	4.09	3.55
Physical effort required	3.45	3.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.73	3.55
Outcome depends on the skill and judgment of physician	4.27	3.64
Estimated risk of malpractice suit with poor outcome	3.91	3.64

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.82	3.45
Intra-Service intensity/complexity	4.00	3.45
Post-Service intensity/complexity	3.00	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.*

Compelling Evidence [Please see our cover letter for the overall Harvard and RUC history and compelling evidence arguments for all of the soft tissue tumor codes]:

1. Evidence that incorrect assumptions were made in the previous valuation of the service.

Current code 21930 (Excision, tumor, soft tissue of back or flank) will be deleted in 2010 and replaced by four new codes (P13, P14, P15, and P16). During the Harvard study, 12 general surgeons were surveyed only for intra-operative time. Pre and post times were predicted. This prediction resulted in no positioning time, no facility post-work (even though the code is typically performed in a facility), and one office visit (even though the procedure wi' typically require at least two office visits during the 90-day global period). The prediction also placed the details fc this code similar to the smallest subcutaneous excision details per the current survey (P13). The time and visit information for 21930 does not represent larger and/or deeper tumors. Further, without requiring a RUC survey in 1995 during the first 5-year-review, the code was reduced based on a comment letter.

2. Evidence that technology has changed physician work (i.e., diffusion of technology).
Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to account for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW *adjusted* down to 12.63 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.069. This is less than the IWPUT for the reference code 38745, which has the same intra-operative time and less total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 21930

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

pecialty 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:22902 Tracking Number P19 Specialty Society Recommended RVU: **4.34**

Global Period: 090 RUC Recommended RVU: **4.34**

CPT Descriptor: Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old female undergoes excision of a 2 cm tumor on her abdominal wall.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 82% , In the ASC 0%, In the office 18%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 93% , Kept overnight (less than 24 hours) 7% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Patient is placed in supine position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery and hemostasis is controlled. The tumor is excised along with proper margin of tissue. Hemostasis is secured with electrocautery and sutures where needed. Small lymphatic channels are ligated. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so they can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are

completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	22902				
Sample Size:	100	**Resp N:**	34	**Response:** 34.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	25.00
Survey RVW:	2.00	4.03	**5.00**	6.00	10.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	30.00	**45.00**	45.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	22902	**Recommended Physician Work RVU: 4.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38525	090	6.35	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep axillary node(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 23.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 22902**	**Key Reference CPT Code:** 38525	**Source of Time** **RUC Time**
Median Pre-Service Time	25.00	45.00	
Median Intra-Service Time	45.00	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	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**148.00**	**178.00**	
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	2.25	2.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.50
Urgency of medical decision making	2.38	2.38

Technical Skill/Physical Effort (Mean)

Technical skill required	2.88	2.88
Physical effort required	2.88	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.75	2.75
Outcome depends on the skill and judgment of physician	3.25	3.38
Estimated risk of malpractice suit with poor outcome	2.88	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.38	2.25
Intra-Service intensity/complexity	2.75	2.63
Post-Service intensity/complexity	2.13	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.*

Currently, there is no CPT code for subcutaneous excision of an abdominal wall soft tissue tumor. According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: No change in time.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends an RVW that is midway between the survey 25th percentile and median to place this subcutaneous code in correct rank order with the rest of the family of subcutaneous codes. Additionally, this value has been *adjusted* (decreased) to 4.34 RVWs to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended time and visit information, this results in an IWPUT of 0.033. This is less than the IWPUT for the reference code 38525, which has the same intra-time and post-work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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? No

If no, please select another crosswalk and provide a brief rationale. 49580

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:22903 Tracking Number P20 Specialty Society Recommended RVU: **6.31**

Global Period: 090 RUC Recommended RVU: **6.31**

CPT Descriptor: Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male undergoes excision of a 5 cm spongy tumor on her abdominal wall.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 82% , Kept overnight (less than 24 hours) 18% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 83%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Patient is placed in supine position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. Local anesthesia is infiltrated into the marked incision site as preemptive analgesia.

Description of Intra-Service Work: An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery to expose the lesion and hemostasis is controlled. The tumor is excised along with proper margin of tissue. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist so ey can coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write ief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain

medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within one week and for at least one more visit through the 90-day global period to remove dressings, assess wound healing, and redress wound; remove sutures; and discuss pathology report when available. Order medications necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progr with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD		
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology		
CPT Code:	22903		
Sample Size:	100	**Resp N:** 34	**Response:** 34.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	8.00	15.00
Survey RVW:	3.50	5.85	**6.50**	7.88	15.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	45.00	**50.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	22903	**Recommended Physician Work RVU: 6.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38525	090	6.35	**RUC Time**

CPT Descriptor Biopsy or excision of lymph node(s); open, deep axillary node(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 23.5 %

TIME ESTIMATES (Median)	CPT Code: 22903	Key Reference CPT Code: 38525	Source of Time RUC Time
Median Pre-Service Time	51.00	45.00	
Median Intra-Service Time	50.00	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	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**179.00**	**178.00**	
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	2.75	2.50
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	2.88	3.13

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	3.25
Physical effort required	3.25	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.38	3.50
Outcome depends on the skill and judgment of physician	3.63	3.75
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.88	3.25
Intra-Service intensity/complexity	3.13	3.00
Post-Service intensity/complexity	2.63	2.88

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.*

Currently, there is no CPT code for subcutaneous excision of an abdominal wall soft tissue tumor. According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

- Pre-Time: With respect to the pre-service time, we recommend package 3 with no changes.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 6.31 to accomplish work neutrality in the family of subcutaneous soft tissue tumor codes. Along with the recommended tir and visit information, this results in an IWPUT of 0.059. This is similar to the IWPUT for the reference code 38525, which has slightly less intra-time and the same total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22904 Tracking Number P23 Specialty Society Recommended RVU: **16.51**

Global Period: 090 RUC Recommended RVU: **16.51**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male presents with a 3 cm sarcoma in the rectus abdominus muscle. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 6% , Admitted (more than 24 hours) 94%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of x-ray, CT, MRI, MRA. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation. Verify that all required instruments and supplies are available. Patient is placed in supine position. 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 trapezius. Medial and lateral subcutaneous flaps are raised. The overlying skin from the biopsy is excised with the tumor. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. The lateral border of the rectus abdominus is identified. The muscle is freed from the underlying oblique muscles but the superficial portion of the oblique transverse abdominus is resected with the tumor. The tumor is removed en bloc, including necessary surrounding structures. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. The surgeon then breaks scrub and carries the specimen to the pathology department while t anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability o the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the

surgical field. The deep fascia is inspected for involvement by the tumor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs and/or peritoneum is carried out. Additional excision is carried out as necessary to obtain a clear margin. Metallic clips are placed to mark the margins for possible postoperative radiotherapy guidance. The wound is inspected and irrigated. Devitalized muscle is debrided. A deep drain is placed. The wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days to check the wound and drain and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	22904				
Sample Size: 100	**Resp N:** 34	**Response:** 34.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	1.00	**2.00**	3.00	10.00
Survey RVW:	13.00	17.00	**18.50**	21.50	35.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	90.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22904	**Recommended Physician Work RVU: 16.51**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
49203	090	20.00	RUC Time

CPT Descriptor Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.5 %

TIME ESTIMATES (Median)	CPT Code: 22904	Key Reference CPT Code: 49203	Source of Time RUC Time
Median Pre-Service Time	63.00	70.00	
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	60.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**396.00**	**420.00**	
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	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.63
Urgency of medical decision making	3.13	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.75
Physical effort required	3.75	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.88
Outcome depends on the skill and judgment of physician	4.25	4.00
Estimated risk of malpractice suit with poor outcome	4.00	4.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	3.63
Intra-Service intensity/complexity	3.88	3.88
Post-Service intensity/complexity	3.75	3.63

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.*

Currently, there is no CPT code for radical resection of an abdominal wall soft tissue tumor. Previously, these procedures may have been reported using one of the following unlisted codes: 20999, 22999, 49999.

Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement.

For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has ncreased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

- Pre-Time: With respect to the pre-service time, we recommend package 4 with no changes

Recommendation: The consensus committee recommends the survey 25th percentile RVW *adjusted* down to 16.51 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey statistic has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.067. This is less than the IWPUT for the reference code 49203 which has more hospital work and is a more complex 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) 20999, 22999, or 49999

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.

ᵓpecialty Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22905 Tracking Number P24 Specialty Society Recommended RVU: **21.37**

Global Period: 090 RUC Recommended RVU: **21.37**

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male presents with a 9 cm sarcoma in the external oblique muscle of the abdominal wall. At operation, the tumor and adjacent soft tissue are resected.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs, pathology reports and imaging studies with special attention to review of x-ray, CT, MRI, MRA. Communicate with reconstructive surgeon. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic and anticoagulation. Verify that all required instruments and supplies are available. Patient is placed in supine position. 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 trapezius. Medial and lateral subcutaneous flaps are raised. The overlying skin from the biopsy is excised with the tumor. The musculature is exposed around the tumor. The fascia is incised and part of it is included with the specimen in the dissection for proper margins. The lateral border of the rectus abdominus is identified. The muscle is freed from the underlying oblique muscles but the superficial portion of the oblique transverse abdominus is resected with the tumor. The tumor is removed en bloc, including necessary surrounding structures. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels e ligated. Frozen sections are taken from the surrounding tissue. The deep fascia is inspected for involvement by the umor as are the ribs and intercostal muscles. If deep margins involved then resection to the periosteum of the ribs and/or peritoneum is carried out. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to

the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. Metallic clips are placed to mark the margins for possible postoperative radiotherapy guidance. The wound is inspected and irrigated. Devitalized muscle is debrided. A deep drain is placed. The wou is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Wound care and close observation are important to avoid or promptly treat wound hematoma. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for pain medication. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office within a few days to check the wound and drain and for several more visits through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order medications as necessary. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD FACS; John Heiner, MD; William Creevy, MD				
Specialty(s):	general surgery; orthopaedic surgery; general and orthopaedic surgical oncology				
CPT Code:	22905				
Sample Size:	100	**Resp N:**	34	**Response:** 34.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	6.00
Survey RVW:	12.00	20.00	**22.00**	25.00	36.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	75.00	124.00	**150.00**	180.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22905	**Recommended Physician Work RVU: 21.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**150.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49203	090	20.00	**RUC Time**

CPT Descriptor Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.5 %

TIME ESTIMATES (Median)	CPT Code: 22905	Key Reference CPT Code: 49203	Source of Time RUC Time
Median Pre-Service Time	63.00	70.00	
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	80.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**463.00**	**420.00**	
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	4.86	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.14
Urgency of medical decision making	4.14	4.29

Technical Skill/Physical Effort (Mean)

Technical skill required	4.71	4.29
Physical effort required	4.43	4.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.29
Estimated risk of malpractice suit with poor outcome	4.71	4.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.57	3.57
Intra-Service intensity/complexity	4.57	4.29
Post-Service intensity/complexity	4.43	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.*

Currently, there is no CPT code for radical resection of an abdominal wall soft tissue tumor. Previously, these procedures may have been reported using one of the following unlisted codes: 20999, 22999, 49999.

Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement.

For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

- Pre-Time: With respect to the pre-service time, we recommend package 4 with no change.

Recommendation: The consensus committee recommends the survey median RVW *adjusted* down to 21.37 to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral (the survey median has been reduced by 2.88%). Along with the recommended time and visit information, this results in an IWPUT of 0.078. The RVW is appropriately greater than the reference code 49203 to account for the additional intra-op time and post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20999, 22999, or 49999

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 Excel File for all soft tissue tumor codes will be provided. How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Excel File for all soft tissue tumor codes will be provided.

Specialty	Frequency	Percentage	%
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

Date: January 5, 2009

To: William L. Rich, III, MD, FACS, Chair, AMA/Specialty Society RVS Update Committee

From: John Heiner, MD, Musculoskeletal Tumor Society
William Creevy, MD, RUC Advisor, American Academy of Orthopaedic Surgeons
Jane Dillon, MD, FACS, RUC Advisor, American Academy of Otolaryngology - Head and Neck Surgery
Martha Matthews, MD, RUC Advisor, American Society of Plastic Surgeons
Daniel Nagle, MD, FACS, RUC Advisor, American Society for Surgery of the Hand
Tye Ouzounian, MD, RUC Advisor, American Orthopaedic Foot and Ankle Society
Christopher Senkowski, MD, FACS, RUC Advisor, American College of Surgeons
Frank Spinosa, DPM, RUC-HCPAC Advisor, American Podiatric Medical Association

Subject: RUC Work Value Recommendations for Excision of Soft Tissue Tumor Codes

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Introduction

On behalf of the Musculoskeletal Tumor Society (MSTS), American Academy of Orthopaedic Surgeons (AAOS), American College of Surgeons (ACS), American Society for Surgery of the Hand (ASSH), American Society of Plastic Surgeons (ASPS), American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), American Orthopaedic Foot and Ankle Society (AOFAS), and the American Podiatric Medical Association (APMA) are pleased to provide (after 14 years of on-going work) physician work RVU recommendations for four groups of soft tissue tumor codes as identified in the RUC agenda for Jan/Feb 2009:

- Subcutaneous Excision of Soft Tissue Tumors (Tab 4)
- Subfascial Excision of Soft Tissue Tumors (Tab 5)
- Radical Excision of Soft Tissue Tumors (Tab 6)
- New Codes for Excision of Soft Tissue Tumors (Tab 7)

CPT and RUC History

In 1994, the AAOS responded to CMS's first 5-year review request for comment on misvalued codes with a letter that included approximately 1,300 codes. Because a significant portion of the musculoskeletal section of CPT were in an extensive revision process at the same time the Harvard Study results were being sent to CMS for the first physician fee schedule, codes were incorrectly crosswalked and anomalies were created. The comment letter included the results of an Abt study, similar to the Harvard study methodology. The AAOS presented this study to the AMA/RUC Research Subcommittee and it was rejected. The AAOS was allowed to withdraw the original comment and submit a modest list of 83 codes believed to be "most" misvalued for survey and review during the first 5-year review. This reduced list of codes was prepared by the AAOS and 11 national orthopaedic subspecialty organizations and was meant to represent the most egregiously misvalued codes. The MSTS identified five soft tissue codes that were surveyed and presented to the RUC. A sixth soft tissue code was also discussed by the RUC and not changed during this first 5 year review, based on a comment from a CMD. All other soft tissue tumor codes were withdrawn from this first 5-year-review.

After this first 5-year-review process, the MSTS and other surgical specialties that perform the soft tissue tumor excision codes began discussions at CPT, as there were several codes that did not exist for all categories of subcutaneous, intramuscular and radical (ie, face/scalp, abdominal wall, and back/flank). A CPT proposal was drafted by the MSTS and the AAOS, but rejected by several surgical specialties because the proposal did not differentiate tumor size.

The MSTS continued CPT revision dialogue with several surgical specialties after the 2nd 5-year-review; however, because of the low volume for these codes and society staffing and resource limitations related to practice expense review activities, a CPT proposal to address the codes was not prepared.

In 2005, the MSTS and the AAOS submitted 14 soft tissue tumor codes for the third 5-year-review. For all of these codes, the RUC (after seeing this issue raised at two other 5-year-reviews), formally recommended referring the soft tissue codes to CPT for clarification of deep excision and possibly creating new codes to differentiate the codes based on the size and depth of the tumor.

In 2006, the MSTS again began discussions at CPT with surgical specialties to develop a proposal to address these codes. At CPT, the project was expanded to a review of all soft tissue tumor codes (including subcutaneous). Additionally, for all of these codes, a significant amount of time was spent on drafting introductory text to define the different types of tumors (ie, subcutaneous, subfascial/intramuscular, radical, and bone). Please refer to the RUC cover page for this text.

Harvard Study History

Of the 31 current soft tissue tumor codes, only six codes were surveyed during the Harvard Study for all components (pre, intra, and post). The other 25 codes were only surveyed for intra-operative time/work, with pre and post-service work predicted by algorithm. Additionally, six codes were *only* reviewed by general surgeons and 25 codes were *only* reviewed by general orthopaedic surgeons. None of the codes were reviewed by plastic surgeons, otolaryngologists, hand surgeons, or podiatrists – all recognized specialties for Medicare and significant providers of these services. Further, none of these codes were reviewed by the majority of the specialists that actually perform them – general and orthopaedic surgical *oncologists*. This poor review and prediction by Harvard resulted in some nonsensical data. For example, 21557 (radical resection of a neck/thorax malignant neoplasm) has only two low level office visits (ie, 99212) associated with it, but 21555 and 21556 (subcutaneous and intramuscular neck/thorax excision) have more office visits imputed by a contractor for CMS for practice expense purposes. A second example is that only two of the 31 codes include any time for positioning. A third example is that nine of the 31 codes have no facility work indicated, when all of these codes (even by the Medicare database) are primarily performed in a facility setting. These same nine codes also have only one office visit during the 90-day global period "predicted" by the Harvard algorithm. A fourth example is that one code surveyed for intra-time only had a 10-day global period assigned to the package for algorithm prediction of pre and post-work. [Note that all surgical specialties that perform these codes agree that the global period should be 90-days and that a minimum of two office visits will always be required.]

Subcutaneous Excision of Soft Tissue Tumors

P7-215X0	P26-230X1	P49-261X0	P69-273X1
P8-215X1	P34-240X0	P50-261X1	P77-276X0
P13-21930	P35-240X1	P58-270X0	P78-276X1
P14-219X1	P42-250X0	P59-270X1	P86-280X0
P25-230X0	P43-250X1	P68-273X0	P87-280X1

There are 10 CPT codes currently for subcutaneous excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes to differentiate the size of the excised lesion. These codes were never presented as misvalued during a 5-Year-Review. At CPT, these codes were added to the review of codes sent to CPT by the RUC. Because these codes were never part of a 5-Year-Review comment letter, the societies involved in the current RUC survey agree these codes should be work neutral. To accomplish this, the survey-based RVW recommendations were reduced by 2.88% (please see attached Table 1).

Subfascial Excision of Soft Tissue Tumors

P9-215X2	P28-230X3	P51-261X2	P71-273X3
P10-215X3	P36-240X2	P52-261X3	P79-276X2
P21-22900	P37-240X3	P60-270X2	P80-276X3
P22-229X2	P44-250X2	P61-270X3	P88-280X2
P27-230X2	P45-250X3	P70-273X2	P89-280X3

There are 10 CPT codes currently for subfascial excision of soft tissue tumors. Nine of these codes were on the RUC agenda during one or more 5-Year-Reviews. So that an anomaly is not created, we recommend that all codes be reviewed. For CPT 2010, these 10 codes have been split into 20 codes to differentiate the size of the excised lesion. We refer the RUC to the SoRs, where detailed compelling evidence is presented specific to each code in the Additional Rationale section, however, in general terms, the following two compelling evidence criteria are cited:

- Evidence that incorrect assumptions were made in the previous valuation of the service. Harvard review of these codes utilized the wrong specialties, not all significant providers of each procedure, and/or incomplete review of codes where pre/and post work was predicted by algorithm resulting in underestimation of relative work.
- Evidence that technology has changed physician work. Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. The excision of deep benign masses (egg, desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy, etc.

To maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the survey based RVW recommendations for the subfascial codes have been reduced by 2.88% (please see attached Table 2).

Radical Excision of Soft Tissue Tumors

P5-21015	P17-21935	P38-240X4	P53-26117	P72-273X4	P84-28046
P6-210X5	P18-219X4	P39-240X5	P54-261X4	P73-273X5	P85-2804X
P11-21557	P29-23077	P46-25077	P62-270X4	P75-27615	
P12-215X4	P30-230X4	P47-250X4	P63-270X5	P76-2761X	

There are 11 CPT codes currently for radical excision of soft tissue tumors. Six of these codes were on the RUC agenda during one or more 5-Year-Reviews based on submission by AAOS. The other five low volume codes are not performed or rarely performed by orthopaedic surgery and were not included in the Academy comment letters. So that an anomaly is not created, we recommend that all codes be reviewed. For CPT 2010, these 11 codes have been split into 22 codes to differentiate the size of the excised lesion. We refer the RUC to the SoRs, where detailed compelling evidence is presented specific to each code in the Additional Rationale section, however, in general terms, the following two compelling evidence criteria are cited:

- Evidence that incorrect assumptions were made in the previous valuation of the service. Harvard review of these codes utilized the wrong specialties, not all significant providers of each procedure, and/or

incomplete review of codes where pre/and post work was predicted by algorithm resulting in underestimation of relative work.

- Evidence that technology has changed physician work. Over the past ten years, significant advancement has been made in the treatment of soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

To maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the survey based RVW recommendations for the radical codes have been reduced by 2.88% (please see attached Table 3).

New Codes for Excision of Soft Tissue Tumors

P1-210X1	P3-210X3	P15-219X2	P19-229X0	P23-229X3
P2-210X2	P4-210X4	P16-219X3	P20-229X1	P24-229X4

As part of the review of the excision of soft tissue tumor codes, ten new codes that did not previously exist were created – 4 subcutaneous, 4 subfascial, and 2 radical excision codes.

New Subcutaneous Codes: There are four new subcutaneous codes. According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new subcutaneous code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used for the subcutaneous codes. As a "back of the envelope calculation," adjustments were made to the RVWs for the benign/malignant lesion codes to take into account additional work (time and visits) for the new codes based on current survey data. The results indicate that the recommended RVW for the new 90-day global codes indicate neutrality or savings when compared with the 10-day global lesion codes (adjusted for difference in time and one addition office visit). This is a conservative estimate because there are no restrictions on the 10-day global codes for number of office visits after 10 days. Whereas the 90-day codes will include only two visits. As presented on each SoR and to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the survey-based RVW recommendations for the new subcutaneous codes have been reduced by 2.88% (please see attached Table 4).

New Subfascial Codes: There are 4 new subfascial/intramuscular codes. According to August 2000 CPT Assistant, when the lesions are located in deep subfascial or submuscular tissues, the appropriate code from the musculoskeletal system should be reported to describe the work entailed. However, there are no specific codes for excision of face/scalp or back/flank subfascial/intramuscular tumors. Unlisted codes 21499, 21899, 22899 or 20999 should have been reported. As presented on each SoR and to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the survey-based RVW recommendations for the new subfascial codes have been reduced by 2.88% (please see attached Table 4).

New Radical Codes: There are 2 new radical excision codes. These low frequency codes should have been reported using the unlisted codes 20999, 22999, or 49999. As presented on each SoR and to maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the

survey-based RVW recommendations for the new subfascial codes have been reduced by 2.88% (please see attached Table 4).

Methodology

The MSTS and the AAOS, along with the ACS, AAO-HNS, ASPS, ASSH, AOFAS, and APMA conducted a full RUC survey for each of the 72 soft tissue tumor codes, with varying involvement. Surveying specialties for each code are shown the Summary of Recommendation forms. Multiple conference calls before, during and after the survey process were held to be certain everyone was involved. We attempted to identify surgeons familiar with the procedures to survey and except for some of the very low volume codes, a minimum of 30 survey responses was obtained and almost all respondents had experience for the codes they were reviewing. In developing our recommendations for pre-service time, we utilized the pre-time packages. For some codes, we also added time in a standardized fashion for positioning beyond supine (eg, prone, lateral, beach chair). For each code, a description of pre-time changes (additions and subtractions) is presented in the rationale section.

All codes were reviewed separately and together to be certain rank order was correct within and between families. Subsequently, based on the adjustment (-3.06%) to the subcutaneous family of codes to maintain work-neutrality, all other survey-based recommendations were reduced / adjusted.

Very few of these codes (primarily small subcutaneous) will be priced in the office setting. Practice expense forms and spreadsheets have been provided.

Frequency and Impact

Although we understand that an estimate for frequency split for current codes and frequency estimate for new codes is important for CMS conversion factor calculations, we find if very difficult to predict with any comfort what the Medicare utilization will be for the soft tissue tumor codes. The typical patient is not Medicare-age for any of these procedures. After querying all specialty participants, we created a table that shows our best attempt to estimate the percentage split of each code into code pairs of small and large tumors. We also included estimates for the new codes. Utilizing the "adjusted" work RVU recommendations and 2007 Medicare frequency data, the estimated Medicare impact for the subcutaneous codes in Tab 4 is zero because these recommendations have been made budget neutral. For the family of subfacial codes in Tab 5, the estimated impact is 48K RVUs. For the family of radical excision of soft tumors in Tab 6, the estimated impact is 49K RVUs. For the new code pairs in Tab 7, the estimated impact will be zero or negative (ie, savings) as these codes represent a shift of reporting from other current codes, including codes with a 10-day global period where multiple E/Ms could be reported after the 10 day period.

Summary

We appreciate the counsel offered at the RUC prefacilitation committee discussions. Specifically, we reduced the RVW recommendations for the subcutaneous codes to maintain work neutrality within that family because those codes were never presented as misvalued at a 5YR. Additionally, we removed additional pre-service *evaluation* time for the radical codes and accepted the pre-time package times. We also appreciate that the prefacilitation committee took time at the last RUC meeting to go over compelling evidence code by code for many of the subfascial and radical codes – accepting the arguments presented. Specifically, that the data for most of the codes is based on a flawed Harvard review of the wrong specialty for intra-time only. With respect to the few codes that were not presented in a 5YR comment letter, the prefacilitation committee agreed that those codes would need to be considered so as not to create rank order anomalies.

We understand that this is a large number of codes that need to be valued relative to each other and more importantly relative to all other codes in the PFS. The participating specialties have spent an extraordinary amount of time developing recommendations that accomplish this task. We hope that the RUC will take the

time necessary to review these codes individually and fairly. A similarly large number of codes came to the RUC at the last 5YR (E/M codes). The process the RUC used to set anchors and work code by code to fit the rest of the codes within the anchors delivered a product that was cohesive and relative to the PFS. This may be a process that can work for the review of this large number of codes.

Attachments

Tab 4 Summary Table
Tab 5 Summary Table
Tab 6 Summary Table
Tab 7 Summary Table
Tabs 4-7 All Codes (Survey, MPC, References)
Tabs 4-7 Frequency Distribution

TAB 4 SUMMARY: Subcutaneous Excision of Soft Tissue Tumor - Work Neutral Recommendations for Revised (split) Codes

old CPT	ID	CPT	Descriptor	2010 Util	2009 RVW	2009 RVUs	2010 RVUs	Adj RVW	Adj Iwput	Survey-based REC STAT	Survey-based REC RVW	Survey-based REC IWPUT	RVW MIN	RVW 25TH	RVW MED	RVW 75TH	RVW MAX	Total Time	PRE PKG	PRE EVAL	PRE POST	PRE 90W	INTRA	POST-HOSP P-SD	POST-HOSP 31	POST-HOSP 39	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11
			SUBCUTANEOUS - SMALL					RUC ACCEPTED SURVEY ADJ RECS																							
26115	P49	26115	Hand/Finger; subcut; < 1.5 cm	4,724	3.92	18,518	18,352	3.88	0.031	blend	4.00	0.035	1.65	3.50	5.00	6.00	10.00	137	1B	14	10	10	30	15		0.5	1	1			
28043	P86	28043	Foot/Toe, subcut, < 1.5cm	2,948	3.58	10,554	11,452	3.88	0.028	med	4.00	0.031	1.65	2.24	4.00	6.00	10.00	138	1B	19	6	5	30	20		0.5	1	1			
25075	P42	25075	Forearm/Wrist; subcut; < 3cm	3,194	3.78	12,073	12,408	3.88	0.031	25th	4.00	0.035	2.50	4.00	5.25	6.00	10.00	137	1B	14	10	10	30	15		0.5	1	1			
27618	P77	27618	Leg/Ankle, subcut, < 3cm	1,342	5.14	6,898	5,213	3.88	0.031	25th	4.00	0.035	1.65	4.00	5.00	8.00	10.00	137	1B	14	10	10	30	15		0.5	1	1			
27327	P68	27327	Thigh/Knee, subcut, < 3cm	2,461	4.52	11,124	9,560	3.88	0.028	25th	4.00	0.032	2.00	4.00	6.00	7.00	12.00	140	1B	14	8	10	30	20		0.5	1	1			
21555	P7	21555	Neck/Thorax, subcut, < 3cm	7,719	4.40	33,964	29,987	3.88	0.027	med	4.00	0.030	2.00	3.19	4.00	6.00	10.00	138	1B	19	6	5	35	15		0.5	1	1			
23075	P25	23075	Shoulder; subcut; < 3cm	1,892	2.41	4,560	7,809	3.88	0.036	med	4.25	0.039	2.00	3.50	4.25	6.00	9.00	142	1B	14	10	10	30	20		0.5	1	1			
24075	P34	24075	Arm / elbow; subcut; < 3cm	3,314	3.96	13,123	13,775	3.88	0.035	25th	4.28	0.040	2.00	4.28	5.00	6.00	10.00	142	1B	14	10	10	30	20		0.5	1	1			
21930	P13	21930	Back/Flank, subcut, < 3cm	8,245	5.06	41,720	40,038	3.88	0.035	med	5.00	0.039	2.00	4.47	5.00	6.00	10.00	165	1B	14	18	10	45	20		0.5	1	1			
27047	P58	27047	Pelvis/Hip, subcut, < 3cm	1,278	7.51	9,598	6,206	3.88	0.040	med	5.00	0.044	2.00	4.00	5.00	6.00	15.00	160	1B	14	18	10	40	20		0.5	1	1			
			SUBCUTANEOUS - LARGE																												
28043	P87	28039	Foot/Toe, subcut, > 1.5cm	328	3.58	1,174	1,752	3.88	0.031	blend	5.50	0.054	2.00	3.90	6.00	8.33	12.00	163	1B	19	6	5	45	20		0.5	1	1			
26115	P50	26111	Hand/Finger; subcut; > 1.5 cm	525	3.92	2,058	2,804	3.88	0.047	med	5.50	0.051	2.10	4.00	5.50	7.00	10.00	173	3	33	12	15	40	15		0.5	1	1			
24075	P35	24071	Arm / elbow; subcut; > 3cm	368	3.96	1,457	2,069	3.88	0.035	25th	5.79	0.049	3.00	5.79	7.00	8.00	18.00	183	3	33	12	15	45	20		0.5	1	1			
25075	P43	25071	Forearm/Wrist; subcut; > 3cm	355	3.78	1,342	2,069	3.88	0.042	med	6.00	0.056	3.00	5.00	6.00	7.00	10.50	178	3	33	12	15	45	15		0.5	1	1			
27327	P69	27337	Thigh/Knee, subcut, > 3cm	273	4.52	1,234	1,591	3.88	0.051	25th	6.00	0.055	3.50	6.00	8.00	10.00	23.00	181	3	33	10	15	45	20		0.5	1	1			
27618	P78	27632	Leg/Ankle, subcut, > 3cm	149	5.14	766	868	3.88	0.050	25th	6.00	0.054	2.36	6.00	7.00	9.00	12.00	183	3	33	12	15	45	20		0.5	1	1			
23075	P26	23071	Shoulder; subcut; > 3cm	210	2.41	506	1,224	3.88	0.048	med	6.00	0.050	4.00	4.75	6.00	8.00	12.00	191	3	33	20	15	45	20		0.5	1	1			
21555	P8	21552	Neck/Thorax, subcut, > 3cm	858	4.40	3,776	5,500	3.88	0.049	med	6.60	0.052	4.04	6.00	6.60	7.13	12.00	194	3	33	3	15	60	25		0.5	1	1			
21930	P14	21931	Back/Flank, subcut, > 3cm	916	5.06	4,635	6,227	3.88	0.051	med	7.00	0.054	3.50	6.00	7.00	8.75	13.00	206	3	33	20	15	60	20		0.5	1	1			
27047	P59	27043	Pelvis/Hip, subcut, > 3cm	142	7.51	1,066	965	3.88	0.048	med	7.00	0.054	4.00	5.95	7.00	8.55	15.00	206	3	33	20	15	60	20		0.5	1	1			

There are 10 CPT codes currently for subcutaneous excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes to differentiate the size of the excised lesion. These codes were never presented as misvalued during a 5 Year Review. To maintain work neutrality, the survey-based RVW recommendations (Col M) were reduced/adjusted by 2.88%.

TAB 5 SUMMARY: Subfascial Excision of Soft Tissue Tumor - Recommendations for Revised (split) Codes

old CPT	ID	CPT	Descriptor	2010 Utl	2009 RVW	2009 RVUs	2010 RVUs		Adj RVW	Adj Input	SPECIALTY REC STAT	SPECIALTY REC RVW	SPECIALTY REC INPUT	RVW MIN	RVW 25TH	RVW MED	RVW 75TH	RVW MAX	Total Time	PRE PRE	PRE EVAL	PRE POST	PRE SDW	INTRA	POST-HOSPITAL P-SD	POST-HOSPITAL SOS	POST-HOSPITAL LOS	POST-HOSPITAL SD-V	POST-HOSPITAL 32	POST-HOSPITAL 31	POST-HOSPITAL 99	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11
			SUBFASCIAL - SMALL																																		
28045	P88	28045	Foot/Toe, subfasc < 1.5cm	3,034	4.77	14,472	16,206				25th	5.50	0.044	2.25	5.50	8.23	9.81	16.00	169	1B	19	6	5	45	20	FAC	SD				0.5		1	2		
26116	P51	26116	Hand/Finger; subfasc; < 1.5 cm	5,515	5.61	30,939	36,476				med	6.81	0.054	2.25	5.95	6.81	9.00	16.00	201	3	33	12	15	45	15	FAC	SD				0.5		2	1		
25076	P44	25076	Forearm/Wrist; subfasc; < 3 cm	1,529	4.97	7,599	10,113				med	6.81	0.051	4.00	6.50	6.81	8.88	15.00	206	3	33	12	15	45	20	FAC	SD				0.5		2	1		
27619	P79	27619	Leg/Ankle, subfasc < 5cm	965	8.47	8,174	6,560				25th	7.00	0.045	4.00	7.00	8.40	12.00	18.00	225	3	33	23	15	60	20	FAC	SD				0.5		1	2		
24076	P36	24076	Arm / elbow; subfasc; < 5cm	1,628	6.36	10,354	11,858				25th	7.50	0.047	6.00	7.50	9.00	11.50	18.00	229	3	33	20	15	60	20	FAC	SD				0.5		2	1		
21556	P9	21556	Neck/Thorax, subfasc < 5cm	5,043	5.63	28,392	37,958				med	7.75	0.049	5.00	7.00	7.75	11.10	18.00	234	3	33	20	15	60	25	FAC	SD				0.5		2	1		
23076	P27	23076	Shoulder; subfascial; < 5cm	1,758	7.77	13,660	12,805				med	7.50	0.050	6.00	7.50	8.50	9.75	20.00	221	3	33	12	15	60	20	FAC	SD				0.5		2	1		
22900	P21	22900	Abdom Wall, subfasc < 5cm	2,648	6.14	16,259	21,731				blend	8.45	0.054	5.00	7.89	9.00	11.50	20.00	244	3	33	3	15	60	20	FAC	ON	YES	1	1			1	2		
27328	P70	27328	Thigh/Knee, subfasc < 5cm	1,524	5.62	8,565	13,321				25th	9.00	0.056	7.00	9.00	11.50	15.00	30.00	261	3	33	20	15	60	20	FAC	ON	YES	1	1			1	2		
27048	P60	27048	Pelvis/Hip, subfasc < 5cm	859	6.44	5,532	7,508				med	9.00	0.042	5.00	7.50	9.00	12.00	20.00	288	4	40	20	20	75	20	FAC	ON	YES	1	1			1	2		
			SUBFASCIAL - LARGE					old rec																													
26116	P52	26113	Hand/Finger; subfasc; > 1.5 cm	290	5.61	1,627	2,030	7.77			med	8.00	0.062	3.10	6.95	8.00	10.00	18.00	214	3	33	12	15	58	15	FAC	SD				0.5		2	1		
28045	P89	28041	Foot/Toe, subfasc > 1.5cm	160	4.77	763	1,120	8.26			med	8.50	0.068	2.50	6.10	8.50	10.25	18.00	217	3	33	8	15	60	20	FAC	SD				0.5		2	1		
25076	P45	25073	Forearm/Wrist; subfasc; > 3 cm	170	4.97	845	1,190	8.26			med	8.50	0.067	5.00	7.50	8.50	11.38	18.00	221	3	33	12	15	60	20	FAC	SD				0.5		2	1		
27619	P80	27634	Leg/Ankle, subfasc > 5cm	107	8.47	906	1,070	10.30			med	10.50	0.062	5.93	9.25	10.50	14.00	23.00	281	3	33	23	15	70	20	FAC	ON	YES	1	1			2	1		
23076	P28	23073	Shoulder; subfascial; > 5cm	195	7.77	1,515	1,950	10.03			blend	11.25	0.068	8.50	10.00	12.50	15.00	22.00	286	3	33	12	15	75	30	FAC	ON	YES	1	1			2	1		
24076	P37	24073	Arm / elbow; subfasc; > 5cm	181	6.36	1,151	1,810	11.30			25th	11.63	0.074	7.00	11.63	13.00	15.75	22.00	283	3	33	20	15	75	20	FAC	ON	YES	1	1			2	1		
22900	P22	22901	Abdom Wall, subfasc > 5cm	294	6.14	1,805	2,940	14.65			med	12.00	0.073	8.00	11.31	12.00	14.75	22.00	284	3	33	3	15	90	30	FAC	ON	YES	1	1			1	2		
27328	P71	27339	Thigh/Knee, subfasc > 5cm	169	5.62	950	1,859	12.27			25th	12.63	0.071	8.00	12.63	15.00	18.00	35.00	310	4	40	20	20	90	20	FAC	ON	YES	1	1			2	1		
21556	P10	21554	Neck/Thorax, subfasc > 5cm	560	5.63	3,153	6,160	12.47			med	12.84	0.070	7.78	11.00	12.84	14.00	21.00	320	4	40	20	20	90	30	FAC	ON	YES	1	1			2	1		
27048	P61	27045	Pelvis/Hip, subfasc > 5cm	95	6.44	612	1,045	12.63			med	13.00	0.072	8.00	11.00	13.00	16.00	30.00	320	4	40	20	20	90	30	FAC	ON	YES	1	1			2	1		

There are 10 CPT codes currently for subfascial excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes to differentiate the size of the excised lesion. Please see the SoR for each code pair that presents the compelling evidence rationale to review these codes under the 5 year review process.

TAB 6 SUMMARY: Radical Excision of Soft Tissue Tumor - Recommendations for Revised (split) Codes

old CPT	ID	CPT	Descriptor	2010 Util	2009 RVW	2009 RVUs	2010 RVUs	Adj RVW (RUC ACCEPTED SPECIALTY REC)	Adj fwput (RUC ACCEPTED SPECIALTY REC)	SPECIALTY REC STAT	SPECIALTY REC RVW	SPECIALTY REC fWPUT	RVW MIN	RVW 25TH	RVW MED	RVW 75TH	RVW MAX	Total Time	PRE PKG	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSPITAL P-SD	POST-HOSPITAL SOS	POST-HOSPITAL LOS	POST-HOSPITAL SD-V	POST-HOSPITAL 32	POST-HOSPITAL 31	POST-HOSPITAL 38	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11
RADICAL - SMALL																																			
21015	P5	21015	Face/Scalp, radical < 2cm	3,581	5.59	20,018	34,779	9.70	0.054	med	10.00	0.057	6.00	7.50	10.00	12.00	18.00	277	4	40	8	20	75	30	FAC	SD			0.5		3	1	
26617	P53	26117	Hand/Finger; radical; < 3 cm	483	8.62	4,163	4,808	9.85	0.058	med	10.25	0.062	2.40	8.30	10.25	14.03	25.00	271	4	40	12	20	75	20	FAC	SD			0.5		3	1	
28046	P84	28046	Foot/Toe, radical < 3cm	395	10.55	4,167	4,618	12.20	0.051	25th	12.56	0.055	7.53	12.56	15.00	18.25	30.00	334	3	33	8	15	90	25	FAC	ADM	YES	2	1		3	1	
25077	P46	25077	Forearm/Wrist; radical; < 3 cm	668	9.90	6,613	8,518	12.75	0.056	blend	13.13	0.059	6.00	12.00	14.25	18 00	30.00	345	4	40	12	20	100	30	FAC	ON	YES	1	1		3	1	
21557	P11	21557	Neck/Thorax, radical < 5cm	1,631	8.91	14,532	23,760	14.67	0.062	med	15.00	0.056	11.00	12.00	15.00	23.18	26.00	398	4	40	12	20	113	30	FAC	ADM	YES	1	1	1	3	1	
27615	P75	24077	Leg/Ankle, radical < 5cm	984	12.93	12,723	15,291	15.64	0.055	med	16.00	0.059	6.80	14.00	16.00	22.00	30.00	416	4	40	23	20	120	30	FAC	ADM	YES	1	1	1	3	1	
24077	P38	24077	Arm / elbow; radical < 5cm	804	11.95	9,608	12,494	15.54	0.058	25th	16.00	0.061	13.00	16.00	17.00	20.75	28.00	405	4	40	12	20	120	30	FAC	ADM	YES	1	1	1	3	1	
27329	P72	27329	Thigh/Knee, radical < 5cm	1,026	15.68	16,088	15,943	15.54	0.056	blend	16.00	0.060	14.00	18.00	22.25	25.00	40.00	413	4	40	20	20	120	30	FAC	ADM	YES	1	1	1	3	1	
21935	P17	21935	Back/Flank, radical < 5cm	1,271	18.38	23,361	19,750	15.64	0.057	med	16.00	0.061	13.00	15.00	16.00	21.50	31.00	408	4	40	20	20	120	25	FAC	ADM	YES	1	1	1	3	1	
23077	P29	23077	Shoulder; radical; < 5cm	568	18.08	10,269	9,930	17.48	0.062	med	18.00	0.066	12.00	16.00	18.00	22.00	30.00	433	4	40	20	20	140	30	FAC	ADM	YES	1	1	1	3	1	
27049	P62	27049	Pelvis/Hip, radical < 5cm	384	15.20	5,837	8,205	21.37	0.064	med	22.00	0.068	16.00	20.00	22.00	25.00	35.00	496	4	40	3	20	180	30	FAC	ADM	YES	2	1	1	3	1	
RADICAL - LARGE																																			
26617	P54	26118	Hand/Finger; radical; > 3 cm	25	8.62	219	370	14.67	0.066	med	15.00	0.070	5.10	10.38	15.00	21.00	30.00	368	4	40	12	20	100	20	FAC	ON	YES		1	1	1	2	2	
21015	P6	21016	Face/Scalp, radical > 2cm	398	5.59	2,225	5,991	10.05	0.060	med	15.50	0.065	6.50	12.55	15.50	19.00	26.86	398	4	40	8	20	100	30	FAC	ADM	YES	1	1	1	1	2	1	
28046	P85	28046	Foot/Toe, radical > 3cm	21	10.55	222	362	17.22	0.069	med	17.75	0.073	9.25	15.23	17.75	22.00	30.00	413	4	40	8	20	120	25	FAC	ADM	YES	1	1	1	1	2	1	
25077	P47	25078	Forearm/Wrist; radical; > 3 cm	35	9.90	347	612	17.48	0.070	med	18.00	0.074	8.50	14.22	18.00	22.00	30.00	422	4	40	12	20	120	30	FAC	ADM	YES	1	1	1	1	2	1	
27615	P76	27616	Leg/Ankle, radical > 5cm	109	12.93	1,409	2,117	19.42	0.067	25th	20.00	0.071	14.00	20.00	22.40	25.00	31.00	463	4	40	23	20	150	30	FAC	ADM	YES	1	1	1	1	2	1	
24077	P39	24079	Arm / elbow; radical > 5cm	89	11.95	1,064	1,815	20.40	0.070	med	21.00	0.074	15.00	20.00	21.00	24.00	32.00	472	4	40	12	20	150	30	FAC	ADM	YES	1	2	1	1	2	1	
21557	P12	21558	Neck/Thorax, radical > 5cm	181	8.91	1,613	3,867	21.37	0.068	med	22.00	0.072	15.00	20.00	22.00	25.70	30.00	502	4	40	12	20	160	30	FAC	ADM	YES	2	1	1	1	2	1	
23077	P30	23078	Shoulder; radical; > 5cm	63	18.08	1,139	1,407	22.29	0.072	med	23.00	0.076	17.00	21.00	23.00	25.50	45.00	490	4	40	20	20	180	30	FAC	ADM	YES	1	1	1	1	2	1	
21935	P18	21936	Back/Flank, radical > 5cm	141	18.38	2,592	3,150	22.34	0.073	med	23.00	0.077	19.00	21.00	23.00	27.00	40.00	510	4	40	20	20	160	30	FAC	ADM	YES	2	1	1	1	2	1	
27329	P73	27364	Thigh/Knee, radical > 5cm	114	15.68	1,788	2,768	24.24	0.074	med	25.00	0.078	18.00	23.00	25.00	30.00	50.00	550	4	40	20	20	180	30	FAC	ADM	YES	2	2	1	1	2	1	
27049	P63	27059	Pelvis/Hip, radical > 5cm	96	15.20	1,459	2,797	29.04	0.077	med	30.00	0.081	21.00	26.22	30.00	31.00	40.00	608	4	40	3	20	220	45	FAC	ADM	YES	2	3	1	1	2	1	

There are 11 CPT codes currently for subfascial excision of soft tissue tumors. For CPT 2010, these 11 codes have been split into 22 codes to differentiate the size of the excised lesion. Please see the SoR for each code pair that presents the compelling evidence rationale to review these codes under the 5 year review process.

1121

TAB 7 SUMMARY: Recommendations for New Soft Tissue Tumor Codes

	A	B	C	D	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AJ	AK	AN	AO	AP	AQ	AR
4										♦	♦																									
5	old				Est	2009	2009	2010		Adj	Adj	SPECIALTY REC			RVW					Total	PRE	PRE				POST-HOSPITAL						POST-OFFICE				
6	CPT	ID	CPT	Descriptor	Util	RVW	IWPUT	RVUs		RVW	IWPUT	STAT	RVW	IWPUT	MIN	25TH	MED	75TH	MAX	Time	PKG	EVAL	POSIT	SDW	INTRA	P-SD	SOS	LOS	SD-V	31	38	15	14	13	12	11
7				SUBCUT - SMALL						RUC ACCEPTED SPEC ADJ RECS																										
8	n/a	P1	21011	Face/Scalp, subcut, < 2cm	6,300	new		18,356		2.91	0.023	med	3.00	0.026	1.70	2.50	3.00	4.13	7.50	98	6	22	6	0	30	10	OFF				0.0			1	1	
9	n/a	P2	21012	Face/Scalp, subcut, > 2cm	700	new		3,059		[illegible]	0.032	med	4.50	0.035	2.20	3.65	4.50	6.20	9.00	148	1B	19	6	5	45	15	FAC	SD			0.5			1	1	
10	n/a	P19	22902	Abdom Wall, subcut, < 3cr	3,150	new		13,675		[illegible]	[illegible]	blend	4.47	0.035	2.00	4.03	5.00	6.00	10.00	148	1B	14	1	10	45	20	FAC	SD			0.5			1	1	
11	n/a	P20	22903	Abdom Wall, subcut, > 3cr	350	new		2,209		[illegible]	[illegible]	med	6.50	0.062	3.50	5.85	6.50	7.88	15.00	179	3	33	3	15	50	20	FAC	SD			0.5			1	1	

There are 4 new subcutaneous codes. To maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the recommended RVWs (Col M) have been reduced by 2.88% (Col J). According to August 2000 CPT Assistant, when lipomas are excised from skin or subcutaneous tissue, it would be appropriate to utilize the integumentary system excision of benign lesion codes (11400-11446). However, the new code descriptors refer to "tumors" without reference to benign or malignant, so the malignant lesion codes may also apply (11600-11646). Additionally, unlisted code 17999 may have been used.

As a "back of the envelope calculation," adjustments were made to the RVWs for the benign/malignant lesion codes to take into account additional work (time and visits) for the new codes. The results shown above in Column J indicate that the recommended RVW for the new 90-day global codes indicate neutrality or savings when compared with the 10-day global lesion codes (adjusted for difference in time and one addition office visit). This is a conservative estimate because there are no restrictions on the 10-day global codes for number of office visits after 10 days. Whereas the 90-day codes include only two visits.

16				SUBFASCIAL - SMALL					old rec	RUC REC																										
17	n/a	P3	21013	Face/Scalp, subfasc < 2cm	4,500	new		24,037		[illegible]	0.043	med	5.50	0.047	2.00	4.38	5.50	6.66	11.00	174	3	33	8	15	45	15	FAC	SD			0.5			1	1	
18	n/a	P4	21014	Face/Scalp, subfasc > 2cm	500	new		3,500	7.63	7.00	0.045	med	7.75	0.056	3.20	6.00	7.75	10.00	15.00	217	3	33	8	15	60	20	FAC	SD			0.5			2	1	
19	n/a	P15	21932	Back/Flank, subfasc < 5cm	2,700	new		26,222		[illegible]	[illegible]	med	10.00	0.058	5.00	9.00	10.00	12.00	17.00	276	3	33	20	15	75	20	FAC	ON	YES	1	1			1	2	
20	n/a	P16	21933	Back/Flank, subfasc > 5cm	300	new		3,300	12.63	11.00	[illegible]	med	13.00	0.073	6.60	12.00	13.00	15.00	20.00	315	4	40	20	20	90	25	FAC	ON	YES	1	1			2	1	

There are 4 new subfascial/intramuscular codes. To maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the recommended RVWs (Col M) have been reduced by 2.88% (Col J). According to August 2000 CPT Assistant, when the lesions are located in deep subfascial or submuscular tissues, the appropriate code from the musculoskeletal system should be reported to describe the work entailed. However, there are no specific codes for excision of face/scalp or back/flank subfascial/intramuscular tumors. Unlisted codes 21499, 21899, 22899 or 20999 may have been reported.

25				RADICAL - SMALL						RUC REC																										
26	n/a	P23	22904	Abdom Wall, radical < 5cm	540	new		8,916		[illegible]	[illegible]	25th	17.00	0.071	13 00	17.00	18.50	21.50	35.00	396	4	40	3	20	120	30	FAC	ADM	YES	1	1			3	1	
27	n/a	P24	22905	Abdom Wall, radical > 5cm	60	new		1,282		[illegible]	[illegible]	med	22.00	0.082	12.00	20.00	22.00	25.00	36.00	463	4	40	3	20	150	30	FAC	ADM	YES	2	1		1	2	1	
28																																				

TAB 7 SUMMARY: Recommendations for New Soft Tissue Tumor Codes

	A	B	C	D	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AJ	AK	AN	AO	AP	AQ	AR
3																																					
4										♦	♦																									
5	old				Est	2009	2009	2010		Adj	Adj	SPECIALTY REC			RVW					Total	PRE	PRE				POST-HOSPITAL							POST-OFFICE				
6	CPT	ID	CPT	Descriptor	Util	RVW	IWPUT	RVUs		RVW	IWPUT	STAT	RVW	IWPUT	MIN	25TH	MED	75TH	MAX	Time	PKG	EVAL	POST	SDW	INTRA	P-SD	SOS	LOS	SD-V	31	30	15	14	13	12	11
29		There are 2 new radical excision codes. To maintain the survey-based relativity in relation to the subcutaneous codes which are being presented as work neutral, the recommended RVWs (Col M) have been reduced by 2.88% (Col J). These low frequency codes should have been reported using the unlisted codes 20999, 22999, or 49999.																																			

TABS 4-7: Excision of Soft Tissue Tumor Codes with Survey Key References & Other MPC Codes

	2006/07						2009	old rec	RUC REC		TOTAL	Hosp	Off	PRE	PRE				POST-HOSP			POST-OFFICE					
	Util	SOURCE	ID	CPT	Descriptor	glob	RVW		REC	IWPUT	Time	vis	vis	PKG	EVAL	POSIT	SDW	INTRA	P-SD	33 32 31	38 39	15 14 13 12 11					CPT
6	48,970	key ref	MPC	11422	Excision, benign lesion including margins	10	1.65		1.65	0.035	56		1		10	0	0	25	5			1					11422
7	57,007	key ref	MPC	11622	Excision, malignant lesion including marg	10	2.36		2.36	0.040	68		1		15			25	5			1					11622
8	147,017	key ref	MPC	11642	Excision, malignant lesion including marg	10	2.57		2.57	0.048	68		1		15			25	5			1					11642
9	6,300	survey	P1	21011	Face/Scalp, subcut, < 2cm	90	new		2.91	0.030	98	0.0	2	6	13	6	0	30	10		0.0	1 1					210X1
10	50,209	key ref	MPC	11643	Excision, malignant lesion including marg	10	3.37		3.37	0.054	93		1		20	5	5	30	10			1					11643
11	22,738	key ref	ref	11406	Excision, benign lesion including margins	10	3.47		3.47	0.032	113		1		10	5	5	60	10			1					11406
12	1,038,900	OTHER	MPC	45378	Colonoscopy, flexible, proximal to splenic	0	3.69		3.69	0.092	75		0		20	5	5	30	15								45378
13	4,199	OTHER	MPC	57155	Insertion of uterine tandems and/or vagir	90	6.79		3.79	0.005	181	0.5	2		48			55	20		0.5	1 1					57155
14	3,194	survey	P42	25075	Forearm/Wrist; subcut; < 3cm	90	3.78		3.88	0.031	137	0.5	2	1B	14	10	10	30	15		0.5	1 1					250X0
15	4,724	survey	P49	26115	Hand/Finger; subcut; < 1.5 cm	90	3.92		3.88	0.031	137	0.5	2	1B	14	10	10	30	15		0.5	1 1					261X0
16	1,342	survey	P77	27618	Leg/Ankle, subcut, < 3cm	90	5.14		3.88	0.031	137	0.5	2	1B	14	10	10	30	15		0.5	1 1					276X0
17	7,719	survey	P7	21555	Neck/Thorax, subcut, < 3cm	90	4.40		3.38	0.027	138	0.5	2	1B	19	6	5	35	15		0.5	1 1					215X0
18	2,948	survey	P86	28043	Foot/Toe, subcut, < 1.5cm	90	3.58		3.88	0.028	138	0.5	2	1B	19	6	5	30	20		0.5	1 1					280X0
19	2,461	survey	P68	27327	Thigh/Knee, subcut, < 3cm	90	4.52		4.68	0.028	140	0.5	2	1B	14	8	10	30	20		0.5	1 1					273X0
20	1,892	survey	P25	23075	Shoulder; subcut; < 3cm	90	2.41		4.13	0.035	142	0.5	2	1B	14	10	10	30	20		0.5	1 1					230X0
21	3,314	survey	P34	24075	Arm / elbow; subcut; < 3cm	90	3.96		4.16	0.035	142	0.5	2	1B	14	10	10	30	20		0.5	1 1					240X0
22	16,637	OTHER	MPC	11644	Excision, malignant lesion including marg	10	4.29		4.29	0.057	108		1		20	5	5	45	10			1					11644
23	3,150	survey	P19	22902	Abdom Wall, subcut, < 3cm	90	new		4.64	0.033	148	0.5	2	1B	14	1	10	45	20		0.5	1 1					229X0
24	61,990	key ref	MPC	13121	Repair, complex, scalp, arms, and/or leg	10	4.36		4.36	0.048	117		2		10			60	15			2					13121
25	700	survey	P2	21012	Face/Scalp; subcut, > 2cm	90	new		4.37	0.032	148	0.5	2	1B	19	6	5	45	15		0.5	1 1					210X2
26	1,278	survey	P58	27047	Pelvis/Hip, subcut, < 3cm	90	7.51		4.86	0.040	160	0.5	2	1B	14	18	10	40	20		0.5	1 1					270X0
27	8,245	survey	P13	21930	Back/Flank, subcut, < 3cm	90	5.06		4.86	0.036	165	0.5	2	1B	14	18	10	45	20		0.5	1 1					21930
28	25,882	key ref	MPC	11606	Excision, malignant lesion including marg	10	4.97		4.97	0.036	153		1		20	5	5	90	10			1					11606
29	5,932	key ref	ref	46040	Incision and drainage of ischiorectal and	90	5.26		5.26	0.041	184	0.5	3		30	15	15	30	20		0.5	1 2					46040
30	328	survey	P87	28039	Foot/Toe, subcut, > 1.5cm	90	3.58		5.34	0.051	153	0.5	2	1B	19	6	5	45	20		0.5	1 1					280X1
31	3,034	survey	P88	28045	Foot/Toe, subfasc < 1.5cm	90	4.77		5.34	0.031	169	0.5	3	1B	19	6	5	45	20		0.5	1 2					280X2
32	525	survey	P50	26111	Hand/Finger; subcut; > 1.5 cm	90	3.92		5.35	0.047	173	0.5	2	3	33	12	15	40	15		0.5	1 1					261X1
33	4,500	survey	P3	21013	Face/Scalp, subfasc < 2cm	90	new		5.34	0.043	174	0.5	2	3	33	8	15	45	15		0.5	1 1					210X3
34	12,197	OTHER	MPC	33212	Insertion or replacement of pacemaker p	90	5.51		5.51	0.044	187		1		60			60	60			1					33212
35	368	survey	P35	24071	Arm / elbow; subcut; > 3cm	90	3.96		5.62	0.044	183	0.5	2	3	33	12	15	45	20		0.5	1 1					240X1
36	355	survey	P43	25071	Forearm/Wrist; subcut; > 3cm	90	3.78		5.83	0.052	178	0.5	2	3	33	12	15	45	15		0.5	1 1					250X1
37	273	survey	P69	27337	Thigh/Knee, subcut, > 3cm	90	4.52		5.84	0.051	181	0.5	2	3	33	10	15	45	20		0.5	1 1					273X1
38	149	survey	P78	27632	Leg/Ankle, subcut, > 3cm	90	5.14		5.88	0.050	183	0.5	2	3	33	12	15	45	20		0.5	1 1					276X1
39	210	survey	P26	23071	Shoulder; subcut; > 3cm	90	2.41		5.88	0.046	191	0.5	2	3	33	20	15	45	20		0.5	1 1					230X1
40	51,382	key ref	ref	20680	Removal of implant; deep (eg, buried wir	90	5.90		5.90	0.056	181	0.5	2		35	15	15	50	15		0.5	2					20680
41	350	survey	P20	22903	Abdom Wall, subcut, > 3cm	90	new		6.30	0.049	179	0.5	2	3	33	3	15	50	20		0.5	1 1					229X1

TABS 4-7: Excision of Soft Tissue Tumor Codes with Survey Key References & Other MPC Codes

	2006/07						2009	old rec	RUC REC		TOTAL	Hosp	Off	PRE	PRE				POST-HOSP			POST-OFFICE		
	Util	SOURCE	ID	CPT	Descriptor	glob	RVW		REC	IWPUT	Time	vis	vis	PKG	EVAL	POSIT	SDW	INTRA	P-SD	33	32-31	38-39	15-14-13-12-11	CPT
42	36,120	key ref	ref	38525	Biopsy or excision of lymph node(s); ope	90	6.35		6.35	0.059	178	0.5	2		45			45	30			0.5	1 1	38525
43	858	survey	P8	21552	Neck/Thorax, subcut, > 3cm	90	4.40		6.41	0.049	194	0.5	2	3	33	3	15	60	25			0.5	1 1	215X1
44	133,289	key ref	ref	13132	Repair, complex, forehead, cheeks, chin	10	6.48		6.48	0.081	136		2		30			45	15				2	13132
45	24,065	OTHER	MPC	49585	Repair umbilical hernia, age 5 years or o	90	6.51		6.51	0.063	178	0.5	2		45			45	30			0.5	1 1	49585
46	5,515	survey	P51	26116	Hand/Finger; subfasc; < 1.5 cm	90	5.61		6.61	0.049	201	0.5	3	3	33	12	15	45	15			0.5	2 1	261X2
47	1,529	survey	P44	25076	Forearm/Wrist; subfasc; < 3 cm	90	4.97		6.61	0.047	206	0.5	3	3	33	12	15	45	20			0.5	2 1	250X2
48	9,700	key ref	MPC	38510	Biopsy or excision of lymph node(s); ope	10	6.69		6.69	0.082	152	0.5	1		45			45	20			0.5	1	38510
49	916	survey	P14	21931	Back/Flank, subcut, > 3cm	90	5.06		6.80	0.051	206	0.5	2	3	33	20	15	60	20			0.5	1 1	219X1
50	142	survey	P59	27043	Pelvis/Hip, subcut, > 3cm	90	7.51		6.80	0.051	206	0.5	2	3	33	20	15	60	20			0.5	1 1	270X1
51	965	survey	P79	27619	Leg/Ankle, subfasc < 5cm	90	8.47		6.80	0.042	225	0.5	3	3	33	23	15	60	20			0.5	1 2	276X2
52	NEW	key ref	ref	25109	Excision of tendon, forearm and/or wrist,	90	6.81		6.81	0.063	191	0.5	3		25	10	15	40	20			0.5	2 1	25109
53	290	survey	P52	26113	Hand/Finger; subfasc; > 1.5 cm	90	5.61	7.77	7.00	0.045	214	0.5	3	3	33	12	15	58	15			0.5	2 1	261X3
54	500	survey	P4	21014	Face/Scalp, subfasc > 2cm	90	new	7.63	7.00	0.043	217	0.5	3	3	33	8	15	60	20			0.5	2 1	210X4
55	160	survey	P89	28041	Foot/Toe, subfasc > 1.5cm	90	4.77	8.26	7.00	0.043	217	0.5	3	3	33	8	15	60	20			0.5	2 1	280X3
56	170	survey	P45	25073	Forearm/Wrist; subfasc; > 3 cm	90	4.97	8.26	7.00	0.042	221	0.5	3	3	33	12	15	60	20			0.5	2 1	250X3
57	1,758	survey	P27	23076	Shoulder; subfascial; < 5cm	90	7.77		7.28	0.048	221	0.5	3	3	33	12	15	60	20			0.5	2 1	230X2
58	1,628	survey	P36	24076	Arm / elbow; subfasc; < 5cm	90	6.36		7.28	0.043	229	0.5	3	3	33	20	15	60	20			0.5	2 1	240X2
59	5,043	survey	P9	21556	Neck/Thorax, subfasc < 5cm	90	5.63		7.53	0.045	234	0.5	3	3	33	20	15	60	25			0.5	2 1	215X2
60	57,897	OTHER	MPC	67904	Repair of blepharoptosis; (tarso) levator	90	7.83		7.83	0.089	185	0.5	4		10	10	15	45	15			0.5	1 3	67904
61	94,768	key ref	MPC	49505	Repair initial inguinal hernia, age 5 years	90	7.88		7.88	0.065	198	0.5	2		20	15	15	70	20			0.5	1 1	49505
62	2,803	key ref	ref	28289	Hallux rigidus correction with cheilectom	90	8.11		8.11	0.069	197		4		30			45	30				4	28289
63	2,648	survey	P21	22900	Abdom Wall, subfasc < 5cm	90	6.14		8.21	0.050	244	2	3	3	33	3	15	60	20		1	1.0	1 2	22900
64	79,586	OTHER	MPC	14040	Adjacent tissue transfer or rearrangemer	90	8.44		8.44	0.050	223		4		15	10	5	90	25				2 2	14040
65	1,524	survey	P70	27328	Thigh/Knee, subfasc < 5cm	90	5.62		8.74	0.052	261	2	3	3	33	20	15	60	20		1	1.0	1 2	273X2
66	859	survey	P60	27048	Pelvis/Hip, subfasc < 5cm	90	6.44		8.74	0.089	288	2	3	4	40	20	20	75	20		1	1.0	1 2	270X2
67	344	key ref	ref	29891	Arthroscopy, ankle, surgical, excision of	90	9.47		9.47	0.069	227		4		50			60	25				4	29891
68	2,700	survey	P15	21932	Back/Flank, subfasc < 5cm	90	new		9.70	0.055	276	2	3	3	33	20	15	75	20		1	1.0	1 2	219X2
69	3,581	survey	P5	21015	Face/Scalp, radical < 2cm	90	5.59		9.71	0.053	277	0.5	4	4	40	8	20	75	30			0.5	3 1	21015
70	19,525	key ref	MPC	15100	Split-thickness autograft, trunk, arms, leg	90	9.74		9.74	0.053	281	2	4		45	10	10	60	20		1	1.0	2 2	15100
71	596	key ref	ref	25115	Radical excision of bursa, synovia of wris	90	9.89		9.89	0.050	257		4		45			90	30				4	25115
72	483	survey	P53	26117	Hand/Finger; radical; < 3 cm	90	8.62		9.95	0.056	271	0.5	4	4	40	12	20	75	20			0.5	3 1	26117
73	107	survey	P80	27634	Leg/Ankle, subfasc > 5cm	90	8.47	10.20	10.00	0.055	281	2	3	4	33	23	15	70	20		1	1.0	2 1	276X3
74	294	survey	P22	22901	Abdom Wall, subfasc > 5cm	90	6.14	11.65	10.00	0.050	284	2	3	3	33	3	15	90	30		1	1.0	1 2	229X2
75	195	survey	P28	23073	Shoulder; subfascial; > 5cm	90	7.77	10.93	10.00	0.052	285	2	3	4	33	12	15	75	30		1	1.0	2 1	230X3
76	181	survey	P37	24073	Arm / elbow; subfasc; > 5cm	90	6.36	11.30	10.00	0.050	295	2	3	4	40	20	20	75	20		1	1.0	2 1	240X3
77	11,005	key ref	ref	25447	Arthroplasty, interposition, intercarpal or	90	10.95		10.95	0.058	278	0.5	5		20	15	10	100	20			0.5	2 3	25447

TABS 4-7: Excision of Soft Tissue Tumor Codes with Survey Key References & Other MPC Codes

	A	B	C	D	E	G	H	I	J	K	Q	R	S	T	U	V	W	X	Y	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AP
4	2006/07						2009	old rec	RUC REC		TOTAL	Hosp	Off	PRE	PRE				POST-HOSP							POST-OFFICE				
5	Util	SOURCE	ID	CPT	Descriptor	glob	RVW		REC	IWPUT	Time	vis	vis	PKG	EVAL	POSIT	SDW	INTRA	P-SD	33	32	31	38	39	15	14	13	12	11	CPT
78	169	survey	P71	27339	Thigh/Knee, subfasc > 5cm	90	5.62	12.27	11.00	0.062	310	2	3	4	40	20	20	90	20		1		1.0				2	1			273X3
79	300	survey	P16	21933	Back/Flank, subfasc > 5cm	90	new	12.63	11.00	0.051	315	2	3	4	40	20	20	90	25		1		1.0				2	1			219X3
80	560	survey	P10	21554	Neck/Thorax, subfasc > 5cm	90	5.63	12.47	11.00	0.050	320	2	3	4	40	20	20	90	30		1		1.0				2	1			215X3
81	95	survey	P61	27045	Pelvis/Hip, subfasc > 5cm	90	6.44	12.63	11.00	0.060	320	2	3	4	40	20	20	90	30		1		1.0				2	1			270X3
82	3,269	key ref	ref	28299	Correction, hallux valgus (bunion), with o	90	11.39		11.39	0.058	299	0.5	4		75			90	30				0.5				3	1			28299
83	40,809	key ref	MPC	49560	Repair initial incisional or ventral hernia;	90	11.84		11.84	0.091	223	0.5	2		45			90	30				0.5				1	1			49560
84	395	survey	P84	28046	Foot/Toe, radical < 3cm	90	10.55		12.20	0.051	334	3	4	3	33	8	15	90	25		2		1.0				3	1			28046
85	8,404	OTHER	MPC	60220	Total thyroid lobectomy, unilateral; with o	90	12.29		12.29	0.092	236	0.5	2		63			90	25				0.5				1	1			60220
86	857	key ref	ref	38700	Suprahyoid lymphadenectomy	90	12.68		12.68	0.073	300	2	3		30	15	15	90	30		1		1.0				2	1			38700
87	668	survey	P46	25077	Forearm/Wrist; radical; < 3 cm	90	9.90		12.75	0.055	345	2	4	4	40	12	20	100	30		1		1.0				3	1			25077
88	6,032	key ref	ref	47100	Biopsy of liver, wedge	90	12.78		12.78	0.066	345	4	3		75			60	30	1	2		1.0				2	1			47100
89	NEW	key ref	ref	29828	Arthroscopy, shoulder, surgical; biceps te	90	13.00		13.00	0.104	262	0.5	4		40	15	15	75	20				0.5				2	2			29828
90	3,553	key ref	ref	38745	Axillary lymphadenectomy; complete	90	13.71		13.71	0.094	271	0.5	3		58			90	25				0.5			1	1	1			38745
91	NEW	key ref	ref	25609	Open treatment of distal radial intra-artic	90	14.12		14.12	0.058	358	0.5	6		40	10	15	120	30				0.5				4	2			25609
92	25	survey	P54	26118	Hand/Finger; radical; > 3 cm	90	8.62		14.57	0.089	368	2	5	4	40	12	20	100	20		1		1.0			1	2	2			261X4
93	1,631	survey	P11	21557	Neck/Thorax, radical < 5cm	90	8.91		13.97	0.052	398	3	4	4	40	12	20	113	30	1	1		1.0				3	1			21557
94	398	survey	P6	21016	Face/Scalp, radical > 2cm	90	5.59		15.05	0.060	398	3	4	4	40	8	20	100	30	1	1		1.0			1	2	1			210X5
95	17,126	key ref	ref	27880	Amputation, leg, through tibia and fibula;	90	15.24		15.24	0.061	400	7	3		30	15	15	80	20	1	5		1.0				2	1			27880
96	293	key ref	ref	41130	Glossectomy; hemiglossectomy	90	15.51		15.51	0.062	407	4	4		45	15	20	90	30		3		1.0			1	3				41130
97	804	survey	P38	24077	Arm / elbow; radical < 5cm	90	11.95		15.64	0.068	405	3	4	4	40	12	20	120	30	1	1		1.0				3	1			240X4
98	1,271	survey	P17	21935	Back/Flank, radical < 5cm	90	18.38		15.64	0.057	408	3	4	4	40	20	20	120	25	1	1		1.0				3	1			21935
99	1,026	survey	P72	27329	Thigh/Knee, radical < 5cm	90	15.68		11.64	0.046	413	3	4	4	40	20	20	120	30	1	1		1.0				3	1			273X4
100	984	survey	P75	27615	Leg/Ankle, radical < 5cm	90	12.93		15.93	0.055	416	3	4	4	40	23	20	120	30	1	1		1.0				3	1			27615
101	6,393	OTHER	MPC	19318	Reduction mammaplasty	90	15.91		15.91	0.075	321	0.5	4		60			150	30				0.5			1	2	1			19318
102	540	survey	P23	22904	Abdom Wall, radical < 5cm	90	new		16.51	0.067	396	3	4	4	40	3	20	120	30	1	1		1.0				3	1			229X3
103	20,541	OTHER	MPC	58150	Total abdominal hysterectomy (corpus ar	90	17.21		17.21	0.071	394	5	2		45	5	10	120	30	1	3		1.0				2				58150
104	21	survey	P85	28047	Foot/Toe, radical > 3cm	90	10.55		17.23	0.069	413	3	4	4	40	8	20	120	25	1	1		1.0			1	2	1			2804X
105	35	survey	P47	25078	Forearm/Wrist; radical; > 3 cm	90	9.90		17.48	0.070	422	3	4	4	40	12	20	120	30	1	1		1.0			1	2	1			250X4
106	568	survey	P29	23077	Shoulder; radical; < 5cm	90	18.08		17.48	0.052	433	3	4	4	40	20	20	140	30	1	1		1.0				3	1			23077
107	369	key ref	MPC	23395	Muscle transfer, any type, shoulder or up	90	18.29		18.29	0.060	423	2	5		60			160	30		1		1.0				5				23395
108	109	survey	P76	27616	Leg/Ankle; radical > 5cm	90	12.93		19.42	0.067	463	3	4	4	40	23	20	150	30	1	1		1.0			1	2	1			2761X
109	12,343	key ref	MPC	15734	Muscle, myocutaneous, or fasciocutaneo	90	19.62		19.62	0.050	524	4	5		30	15	15	163	30	1	1	1	1.0			1	2	2			15734
110	NEW	key ref	ref	49203	Excision or destruction, open, intra-abdo	90	20.00		20.00	0.089	420	5	3		45	10	15	120	30		1	3	1.0				2	1			49203
111	14,026	OTHER	MPC	35656	Bypass graft, with other than vein; femor	90	20.39		20.39	0.075	447	6	2		90			150	30			5	1.0				1	1			35656
112	89	survey	P39	24079	Arm / elbow; radical > 5cm	90	11.95		20.40	0.049	472	4	4	4	40	12	20	150	30		1	2	1.0			1	2	1			240X5
113	60	survey	P24	22905	Abdom Wall, radical > 5cm	90	new		21.37	0.078	463	4	4	4	40	3	20	150	30		1	2	1.0			1	2	1			229X4

TABS 4-7: Excision of Soft Tissue Tumor Codes with Survey Key References & Other MPC Codes

	A	B	C	D	E	G	H	I	J	K	Q	R	S	T	U	V	W	X	Y	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AP
4	2006/07						2009	old rec	RUC	REC	TOTAL	Hosp	Off	PRE	PRE				POST-HOSP						POST-OFFICE				
5	Util	SOURCE	ID	CPT	Descriptor	glob	RVW		REC	IWPUT	Time	vis	vis	PKG	EVAL	POSIT	SDW	INTRA	P-SD	33	32	31	38	39	15	14	13	12	11	CPT
114	384	survey	P62	27049	Pelvis/Hip, radical < 5cm	90	15.20		24.37	0.0645	496	4	4	4	40	3	20	180	30	2	1		1.0		3	1				270X4
115	181	survey	P12	21558	Neck/Thorax, radical > 5cm	90	8.91		24.37	0.0688	502	4	4	4	40	12	20	160	30	2	1		1.0		1	2	1			215X4
116	63	survey	P30	23078	Shoulder; radical; > 5cm	90	18.08		22.34	0.0721	490	3	4	4	40	20	20	180	30	1	1		1.0		1	2	1			230X4
117	141	survey	P18	21936	Back/Flank, radical > 5cm	90	18.38		22.36	0.0731	510	4	4	4	40	20	20	160	30	2	1		1.0		1	2	1			219X4
118	37,958	OTHER	MPC	44140	Colectomy, partial; with anastomosis	90	22.46		22.46	0.079	480	7	3		30	15	15	150	30	1	5		1.0			2	1			44140
119	12,931	key ref	ref	23472	Arthroplasty, glenohumeral joint; total sh	90	22.47		22.47	0.079	458	4	4		60			165	30	1	2		1.0			3	1			23472
120	1,063	key ref	MPC	24363	Arthroplasty, elbow; with distal humerus	90	22.47		22.47	0.085	466	2	4		50	18	15	150	30	1	2		1.0			3	1			24363
121	263,210	key ref	ref	27447	Arthroplasty, knee, condyle and plateau;	90	23.04		23.04	0.099	469	5	4		45	15	15	124	30	1	3		1.0		1	2	1			27447
122	114	survey	P73	27364	Thigh/Knee, radical > 5cm	90	15.68		24.28	0.0771	550	5	4	4	40	20	20	180	30	2	2		1.0		1	2	1			273X5
123	528	key ref	ref	47380	Ablation, open, of one or more liver tumo	90	24.43		24.43	0.068	550	5	3		85			200	45	2	2		1.0			2	1			47380
124	4,592	OTHER	MPC	44626	Closure of enterostomy, large or small in	90	27.82		27.82	0.090	587	8	2		60			150	30	2	3	2	1.0			1	1			44626
125	96	survey	P63	27059	Pelvis/Hip, radical > 5cm	90	15.20		29.14	0.0777	608	6	4	4	40	3	20	220	45	2	3		1.0		1	2	1			270X5
126	10,925	key ref	MPC	27134	Revision of total hip arthroplasty; both co	90	30.13		30.13	0.074	617	8	3		90			240	40		7		1.0			3				27134
127	2,931	OTHER	MPC	45110	Proctectomy; complete, combined abdor	90	30.57		30.57	0.077	685	9	4		80			180	30	1	3	4	1.0		1	2	1			45110

TABS 4-7: Soft Tissue Tumor Code *Estimated* Distribution

			2007 Util	EST	(estimated) Medicare Specialty Distribution							
ID	CPT	Descriptor	*2010 Split*	*Utilization*	GS	ORT	S-ONC	PS	OTO	HS	POD	OTH
	NEW	NEW	*7,000*		X		X	XXX	XX			XX
P1	21011	Face/Scalp, subcut, < 2cm	*90%*	6,300								
P2	21012	Face/Scalp, subcut, > 2cm	*10%*	700								
	NEW	NEW	*5,000*		X		X	XXX	XX			X
P3	21013	Face/Scalp, subfasc < 2cm	*90%*	4,500								
P4	21014	Face/Scalp, subfasc > 2cm	*10%*	500								
PR	21015	Face/Scalp, radical - any size	3,979		23%	0%	7%	46%	15%	0%	0%	9%
P5	21015	Face/Scalp, radical < 2cm	*90%*	3,581								
P6	21016	Face/Scalp, radical > 2cm	*10%*	398								
Hvd	21555	Neck/Thorax, subcut - any size	8,577		64%	1%	2%	11%	9%	0%	0%	13%
P7	215X0	Neck/Thorax, subcut, < 3cm	*90%*	7,719								
P8	21552	Neck/Thorax, subcut, > 3cm	*10%*	858								
Hvd	21556	Neck/Thorax, subfasc - any size	5,603		51%	1%	2%	9%	30%	0%	0%	7%
P9	21556	Neck/Thorax, subfasc < 5cm	*90%*	5,043								
P10	21554	Neck/Thorax, subfasc > 5cm	*10%*	560								
Hvd	21557	Neck/Thorax, radical - any size	1,812		40%	1%	8%	17%	23%	0%	0%	11%
P11	21557	Neck/Thorax, radical < 5cm	*90%*	1,631								
P12	21558	Neck/Thorax, radical > 5cm	*10%*	181								
Hvd	21930	Back/Flank, subcut/fasc - any size	9,161		76%	2%	1%	7%	0%	0%	0%	14%
P13	21930	Back/Flank, subcut, < 3cm	*90%*	8,245								
P14	21931	Back/Flank, subcut, > 3cm	*10%*	916								
	NEW	NEW	*3,000*		XXX		X	XX				XX
P15	21932	Back/Flank, subfasc < 5cm	*90%*	2,700								
P16	21933	Back/Flank, subfasc > 5cm	*10%*	300								
Hvd	21935	Back/Flank, radical - any size	1,412		53%	3%	10%	25%	0%	0%	0%	10%
P17	21935	Back/Flank, radical < 5cm	*90%*	1,271								
P18	21936	Back/Flank, radical > 5cm	*10%*	141								
	NEW	NEW	*3,500*		XXX		X	X				XX
P19	22902	Abdom Wall, subcut, < 3cm	*90%*	3,150								
P20	22903	Abdom Wall, subcut, > 3cm	*10%*	350								
Hvd	22900	Abdom Wall, subfasc - any size	2,942		79%	0%	3%	3%	0%	0%	0%	15%
P21	22900	Abdom Wall, subfasc < 5cm	*90%*	2,648								
P22	22901	Abdom Wall, subfasc > 5cm	*10%*	294								
	NEW	NEW	*600*		XXX		X	X				X
P23	22904	Abdom Wall, radical < 5cm	*90%*	540								
P24	22905	Abdom Wall, radical > 5cm	*10%*	60								
Hvd	23075	Shoulder; subcut - any size	2,102		68%	17%	1%	5%	0%	0%	0%	8%
P25	23075	Shoulder; subcut; < 3cm	*90%*	1,892								
P26	23071	Shoulder; subcut; > 3cm	*10%*	210								
Hvd	23076	Shoulder; subfasc - any size	1,953		50%	35%	2%	6%	0%	1%	0%	6%
P27	23076	Shoulder; subfascial; < 5cm	*90%*	1,758								
P28	23073	Shoulder; subfascial; > 5cm	*10%*	195								
Hvd	23077	Shoulder; radical - any size	631		38%	17%	10%	25%	0%	0%	0%	9%
P29	23077	Shoulder; radical; < 5cm	*90%*	568								
P30	23078	Shoulder; radical; > 5cm	*10%*	63								
Hvd	24075	Upper arm / elbow; subcut - any size	3,682		61%	17%	1%	9%	0%	2%	0%	11%
P34	24075	Upper arm / elbow; subcut; < 3cm	*90%*	3,314								
P35	24071	Upper arm / elbow; subcut; > 3cm	*10%*	368								
Hvd	24076	Upper arm / elbow; subfasc - any size	1,809		43%	36%	2%	9%	0%	4%	0%	6%
P36	24076	Upper arm / elbow; subfasc; < 5cm	*90%*	1,628								
P37	24073	Upper arm / elbow; subfasc; > 5cm	*10%*	181								
Hvd	24077	Upper arm / elbow; radical - any size	893		37%	19%	10%	25%	0%	1%	0%	8%
P38	24077	Upper arm / elbow; radical < 5cm	*90%*	804								
P39	24079	Upper arm / elbow; radical > 5cm	*10%*	89								

TABS 4-7: Soft Tissue Tumor Code *Estimated* Distribution

			2007 Util	EST	(estimated) Medicare Specialty Distribution							
ID	CPT	Descriptor	*2010 Split*	*Utilization*	GS	ORT	S-ONC	PS	OTO	HS	POD	OTH
Hvd	25075	Forearm/Wrist; subcut - any size	3,549		50%	22%	1%	11%	0%	5%	0%	11%
P42	25075	Forearm/Wrist; subcut; < 3cm	*90%*	3,194								
P43	25071	Forearm/Wrist; subcut; > 3cm	*10%*	355								
Hvd	25076	Forearm/Wrist; subfasc - any size	1,699		24%	46%	2%	11%	0%	12%	0%	5%
P44	25076	Forearm/Wrist; subfasc; < 3 cm	*90%*	1,529								
P45	25073	Forearm/Wrist; subfasc; > 3 cm	*10%*	170								
Hvd	25077	Forearm/Wrist; radical - any size	703		41%	16%	8%	27%	1%	2%	0%	6%
P46	25077	Forearm/Wrist; radical; < 3 cm	*95%*	668								
P47	25078	Forearm/Wrist; radical; > 3 cm	*5%*	35								
Hvd	26115	Hand/Finger; subcut - any size	5,249		8%	56%	0%	14%	0%	18%	0%	5%
P49	26115	Hand/Finger; subcut; < 1.5 cm	*90%*	4,724								
P50	26111	Hand/Finger; subcut; > 1.5 cm	*10%*	525								
Hvd	26116	Hand/Finger; subfasc - any size	5,805		3%	59%	0%	12%	0%	25%	0%	1%
P51	26116	Hand/Finger; subfasc; < 1.5 cm	*95%*	5,515								
P52	26113	Hand/Finger; subfasc; > 1.5 cm	*5%*	290								
Hvd	26117	Hand/Finger; radical - any size	508		11%	41%	2%	30%	0%	16%	0%	1%
P53	26117	Hand/Finger; radical; < 3 cm	*95%*	483								
P54	26118	Hand/Finger; radical; > 3 cm	*5%*	25								
Hvd	27047	Pelvis/Hip, subcut - any size	1,420		74%	10%	1%	4%	0%	0%	0%	11%
P58	27047	Pelvis/Hip, subcut, < 3cm	*90%*	1,278								
P59	27043	Pelvis/Hip, subcut, > 3cm	*10%*	142								
Hvd	27048	Pelvis/Hip, subfasc - any size	954		50%	28%	2%	5%	0%	0%	0%	15%
P60	27048	Pelvis/Hip, subfasc < 5cm	*90%*	859								
P61	27045	Pelvis/Hip, subfasc > 5cm	*10%*	95								
RUC	27049	Pelvis/Hip, radical - any size	480		32%	35%	10%	8%	0%	0%	0%	15%
P62	27049	Pelvis/Hip, radical < 5cm	*80%*	384								
P63	27059	Pelvis/Hip, radical > 5cm	*20%*	96								
Hvd	27327	Thigh/Knee, subcut - any size	2,734		65%	19%	1%	5%	0%	0%	0%	10%
P68	27327	Thigh/Knee, subcut, < 3cm	*90%*	2,461								
P69	27337	Thigh/Knee, subcut, > 3cm	*10%*	273								
Hvd	27328	Thigh/Knee, subfasc - any size	1,693		45%	41%	2%	6%	0%	0%	0%	6%
P70	27328	Thigh/Knee, subfasc < 5cm	*90%*	1,524								
P71	27339	Thigh/Knee, subfasc > 5cm	*10%*	169								
RUC	27329	Thigh/Knee, radical - any size	1,140		29%	41%	10%	9%	0%	0%	0%	11%
P72	27329	Thigh/Knee, radical < 5cm	*90%*	1,026								
P73	27364	Thigh/Knee, radical > 5cm	*10%*	114								
Hvd	27618	Leg/Ankle, subcut - any size	1,491		48%	20%	1%	8%	0%	0%	10%	11%
P77	27618	Leg/Ankle, subcut, < 3cm	*90%*	1,342								
P78	27632	Leg/Ankle, subcut, > 3cm	*10%*	149								
Hvd	27619	Leg/Ankle, subfasc - any size	1,072		28%	35%	3%	8%	0%	0%	20%	6%
P79	27169	Leg/Ankle, subfasc < 5cm	*90%*	965								
P80	27634	Leg/Ankle, subfasc > 5cm	*10%*	107								
Hvd	27615	Leg/Ankle, radical - any size	1,093		36%	15%	6%	34%	0%	0%	4%	6%
P75	27615	Leg/Ankle, radical < 5cm	*90%*	984								
P76	27616	Leg/Ankle, radical > 5cm	*10%*	109								
Hvd	28043	Foot/Toe, subcut - any size	3,275		4%	17%	0%	1%	0%	0%	75%	3%
P86	28043	Foot/Toe, subcut, < 1.5cm	*90%*	2,948								
P87	28039	Foot/Toe, subcut, > 1.5cm	*10%*	328								
Hvd	28045	Foot/Toe, subfasc - any size	3,194		2%	18%	0%	1%	0%	0%	76%	3%
P88	28045	Foot/Toe, subfasc < 1.5cm	*95%*	3,034								
P89	28041	Foot/Toe, subfasc > 1.5cm	*5%*	160								
Hvd	28046	Foot/Toe, radical - any size	416		15%	9%	5%	21%	0%	0%	47%	3%
P84	28046	Foot/Toe, radical < 3cm	*95%*	395								
P85	28047	Foot/Toe, radical > 3cm	*5%*	21								

CPT Code: See Below

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Short Descriptor:

P1	Face/Scalp, subcut, < 2cm	P25	Shoulder; subcut; < 3cm	P58	Pelvis/Hip, subcut, < 3cm
P2	Face/Scalp, subcut, > 2cm	P26	Shoulder; subcut; > 3cm	P59	Pelvis/Hip, subcut, > 3cm
P3	Face/Scalp, subfasc < 2cm	P27	Shoulder; subfascial; < 5cm	P60	Pelvis/Hip, subfasc < 5cm
P4	Face/Scalp, subfasc > 2cm	P28	Shoulder; subfascial; > 5cm	P61	Pelvis/Hip, subfasc > 5cm
P5	Face/Scalp, radical < 2cm	P29	Shoulder; radical; < 5cm	P62	Pelvis/Hip, radical < 5cm
P6	Face/Scalp, radical > 2cm	P30	Shoulder; radical; > 5cm	P63	Pelvis/Hip, radical > 5cm
P7	Neck/Thorax, subcut, < 3cm	P34	Arm / elbow; subcut; < 3cm	P68	Thigh/Knee, subcut, < 3cm
P8	Neck/Thorax, subcut, > 3cm	P35	Arm / elbow; subcut; > 3cm	P69	Thigh/Knee, subcut, > 3cm
P9	Neck/Thorax, subfasc < 5cm	P36	Arm / elbow; subfasc; < 5cm	P70	Thigh/Knee, subfasc < 5cm
P10	Neck/Thorax, subfasc > 5cm	P37	Arm / elbow; subfasc; > 5cm	P71	Thigh/Knee, subfasc > 5cm
P11	Neck/Thorax, radical < 5cm	P38	Arm / elbow; radical < 5cm	P72	Thigh/Knee, radical < 5cm
P12	Neck/Thorax, radical > 5cm	P39	Arm / elbow; radical > 5cm	P73	Thigh/Knee, radical > 5cm
P13	Back/Flank, subcut, < 3cm	P42	Forearm/Wrist; subcut; < 3cm	P75	Leg/Ankle, radical < 5cm
P14	Back/Flank, subcut, > 3cm	P43	Forearm/Wrist; subcut; > 3cm	P76	Leg/Ankle, radical > 5cm
P15	Back/Flank, subfasc < 5cm	P44	Forearm/Wrist; subfasc; < 3 cm	P77	Leg/Ankle, subcut, < 3cm
P16	Back/Flank, subfasc > 5cm	P45	Forearm/Wrist; subfasc; > 3 cm	P78	Leg/Ankle, subcut, > 3cm
P17	Back/Flank, radical < 5cm	P46	Forearm/Wrist; radical; < 3 cm	P79	Leg/Ankle, subfasc < 5cm
P18	Back/Flank, radical > 5cm	P47	Forearm/Wrist; radical; > 3 cm	P80	Leg/Ankle, subfasc > 5cm
P19	Abdom Wall, subcut, < 3cm	P49	Hand/Finger; subcut; < 1.5 cm	P84	Foot/Toe, radical < 3cm
P20	Abdom Wall, subcut, > 3cm	P50	Hand/Finger; subcut; > 1.5 cm	P85	Foot/Toe, radical > 3cm
P21	Abdom Wall, subfasc < 5cm	P51	Hand/Finger; subfasc; < 1.5 cm	P86	Foot/Toe, subcut, < 1.5cm
P22	Abdom Wall, subfasc > 5cm	P52	Hand/Finger; subfasc; > 1.5 cm	P87	Foot/Toe, subcut, > 1.5cm
P23	Abdom Wall, radical < 5cm	P53	Hand/Finger; radical; < 3 cm	P88	Foot/Toe, subfasc < 1.5cm
P24	Abdom Wall, radical > 5cm	P54	Hand/Finger; radical; > 3 cm	P89	Foot/Toe, subfasc > 1.5cm

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 committee of orthopaedic surgeons, general surgeons, surgical oncologists, plastic surgeons, otolaryngologists, foot and ankle orthopaedic surgeons, and podiatrists representing all types of practices and all geographic settings discussed the practice expense details for the new codes shown above. The consensus was that none of these procedures are emergent.

CPT Code: See Below

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management (standard 6 minutes for same day or 12 minutes for overnight/admit) and standard office visit related activities are performed.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Non Facility Direct Inputs

CPT Short Descriptor:

P1	Face/Scalp, subcut, < 2cm	**P49**	Hand/Finger; subcut; < 1.5 cm
P3	Face/Scalp, SUBFASC < 2cm	**P58**	Pelvis/Hip, subcut, < 3cm
P7	Neck/Thorax, subcut, < 3cm	**P68**	Thigh/Knee, subcut, < 3cm
P13	Back/Flank, subcut, < 3cm	**P77**	Leg/Ankle, subcut, < 3cm
P19	Abdom Wall, subcut, < 3cm	**P86**	Foot/Toe, subcut, < 1.5cm
P25	Shoulder; subcut; < 3cm	**P87**	Foot/Toe, subcut, > 1.5cm
P34	Upper arm / elbow; subcut; < 3cm	**P88**	Foot/Toe, SUBFASC < 1.5cm
P42	Forearm/Wrist; subcut; < 3cm		

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 committee of orthopaedic surgeons, general surgeons, surgical oncologists, plastic surgeons, otolaryngologists, foot and ankle orthopaedic surgeons, and podiatrists representing all types of practices and all geographic settings discussed the non-facility practice expense details for the new codes shown above. The consensus was that none of these procedures are emergent.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:
Clincal staff reviews the chart to be certain all pre-procedure testing and images are available and the H&P is current. The patient will be greeted and gowned and vital signs obtained. The procedure is reviewed. The procedure room is prepared, making certain supplies and equipment necessary are available. Clinical staff assists the physician with prepping, positioning, and providing anesthesia. This is a sterile procedure therefore, once the clinical staff is gloved, they will remain in the room and assist the physician with the entire procedure. After completion of the procedure, clinical staff will monitor the patient; clean the room; clean the surgical instruments; prepare diagnostic forms and send the excised specimen to pathology; check dressings; and provide instructions on wound care, follow-up visits, and prescriptions.

Post-Service Clinical Labor Activities
Standard office visit related activities are performed.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	**AMA Specialty Society RVS Update Committee Recommendation**														
2				**P1**		**P3**		**P7**		**P13**		**P19**		**P58**	
3	**Meeting Date: Jan/Feb 2009**			**21011**		**21013**		**21555**		**21930**		**22902**		**27047**	
4				Face/Scalp, subcut, < 2cm		Face/Scalp, SUBFASC < 2cm		Neck/Thorax, subcut, < 3cm		Back/Flank, subcut, < 3cm		Abdom Wall, subcut, < 3cm		Pelvis/Hip, subcut, < 3cm	
5	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**
6	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**158**	**129**	**173**	**129**	**163**	**129**	**173**	**129**	**173**	**129**	**168**	**129**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**6**	**75**	**6**	**65**	**6**	**75**	**6**	**75**	**6**	**70**	**6**
10	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**
11	**PRE-SERVICE**														
12	**Start: Following visit when decision for surgery or procedure made**														
13	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
14	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**
15	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**		**8**		**8**		**8**		**8**		**8**
16	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**
17	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**
18	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA												
19	**End:When patient enters office/facility for surgery/procedure**														
20	**SERVICE PERIOD**														
21	**Start: When patient enters site for procedure: Services Prior to Procedure**														
22	Greet patient and provide gowning	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**	
23	Obtain vital signs	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**	
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**		**2**		**2**		**2**		**2**		**2**	
25	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**		**2**		**2**		**2**		**2**		**2**	
26	**Intra-service**														
27	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**30**		**45**		**35**		**45**		**45**		**40**	
28	**Post-Service**														
29	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**1**		**1**		**1**		**1**		**1**		**1**	
30	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**	
31	Clean Scope	**L037D**	RN/LPN/MTA												
32	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**10**		**10**		**10**		**10**		**10**		**10**	
33	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**	
34	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA												
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**	
36	Discharge day management	**L037D**	RN/LPN/MTA		**6**		**6**		**6**		**6**		**6**		**6**
37	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA												
38	**End: Patient leaves office**														
39	**POST-SERVICE Period**														
40	**Start: Patient leaves office/facility**														
41	Conduct phone calls/call in prescriptions														
42	*List Number and Level of Office Visits*														
43	99211 16 minutes		16												
44	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
45	99213 36 minutes		36	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
46	99214 53 minutes		53												
47	99215 63 minutes		63												
48	Other														
49	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**
50	Other:														
51	**End: with last office visit before end of global period**														

1133

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2				P1		P3		P7		P13		P19		P58	
3	Meeting Date: Jan/Feb 2009			21011		21013		21555		21930		22902		27047	
4				Face/Scalp, subcut, < 2cm		Face/Scalp, SUBFASC < 2cm		Neck/Thorax, subcut, < 3cm		Back/Flank, subcut, < 3cm		Abdom Wall, subcut, < 3cm		Pelvis/Hip, subcut, < 3cm	
5	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility
52	MEDICAL SUPPLIES	Code	Unit												
53	pack, minimum multi-specialty visit	SA048	pack	3	2	3	2	3	2	3	2	3	2	3	2
54	pack, post-op incision care (suture)	SA054	pack	1	1	1	1	1	1	1	1	1	1	1	1
55	scrub brush (impregnated)	SM023	item	2		2		2		2		2		2	
56	mask, surgical	SB033	item	2		2		2		2		2		2	
57	gloves, sterile	SB024	pair	2		2		2		2		2		2	
58	gown, staff, impervious	SB027	item	2		2		2		2		2		2	
59	blade, surgical hair clipper	SF010	item	0.5		0.5		0.5		0.5		0.5		0.5	
60	povidone surgical scrub (Betadine)	SJ042	ml	10		10		10		10		10		10	
61	drape, sterile, for Mayo stand	SB012	item	1		1		1		1		1		1	
62	drape, sterile barrier 16in x 29in	SB007	item	1		1		1		1		1		1	
63	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2		2		2		2		2		2	
64	skin marking pen, sterile (Skin Skribe)	SK075	item	1		1		1		1		1		1	
65	drape, sterile, u-shape	SB015	item			1		1							
66	arm board	SC003	item												
67	bandage, Esmarch-Martin, sterile 3in X 9ft	SG015	item												
68	tourniquet, ankle, sterile	SD123	item												
69	swab-pad, alcohol	SJ053	item	1		1		1		2		2		2	
70	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		10		20		10		10		10	
71	bupivacaine 0.5% inj (Marcaine)	SH021	ml							10		10		10	
72	needle, 18-27g	SC029	item	1		1		1		2		2		2	
73	needle, 30g	SC031	item	1		1		1		2		2		2	
74	syringe 10-12ml	SC051	item	1		1		2		2		2		2	
75	syringe 50-60ml	SC056	item	1		1		1		1		1		1	
76	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1		1		1		1		1	
77	underpad 2ft x 3ft (Chux)	SB044	item	1		1		1		2		2		2	
78	basin, irrigation	SJ009	item							1		1		1	
79	scalpel with blade, surgical (#10-20)	SF033	item	1		1		1		1		1		1	
80	suture, nylon, 3-0 to 6-0, c	SF036	item	1		1		1		1		1		1	
81	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item	1		1		1		1		1		1	
82	cautery, bipolar cord	SF012	item												
83	cautery, bipolar, pencil-handpiece	SF013	item												
84	cautery, monopolar, pencil-handpiece	SF020	item	1		1		1		1		1		1	
85	cautery, patient ground pad w-cord	SF021	item	1		1		1		1		1		1	
86	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		2		2		2	
87	bacitracin oint (0.9gm uou)	SJ007	item	2		2		2		2		2		2	
88	dressing, 5in x 9in (Xeroform)	SG041	item			1		1							
89	tape, surgical paper 1in (Micropore)	SG079	inch	12		12		12		12		12		12	
90	dressing, 3inx4in (Telfa, Release)	SG035	item							1		1		1	
91	bandage, Kerlix, sterile 4.5in	SG016	item												
92	bandage, elastic, self-adherent wrap 1in (Coban)	SG014	item												
93	pack, cleaning, surgical instruments	SA043	pack	1		1		1		1		1		1	
94	cup, biopsy-specimen sterile 4oz	SL036	item	1		1		1		1		1		1	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2				P1		P3		P7		P13		P19		P58	
3	**Meeting Date: Jan/Feb 2009**			21011		21013		21555		21930		22902		27047	
4				Face/Scalp, subcut, < 2cm		Face/Scalp, SUBFASC < 2cm		Neck/Thorax, subcut, < 3cm		Back/Flank, subcut, < 3cm		Abdom Wall, subcut, < 3cm		Pelvis/Hip, subcut, < 3cm	
5	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility
95	**Equipment**	**Code**													
96	table, power	EF031		123	63	138	63	128	63	138	63	138	63	133	63
97	light, surgical	EF014		123	63	138	63	128	63	138	63	138	63	133	63
98	instrument pack, basic ($500-$1499)	EQ137		60		75		65		75		75		70	
99	mayo stand	EF015		60		75		65		75		75		70	
100	electrocautery-hyfrecator, up to 45 watts	EQ110		60		75		65		75		75		70	
101	tourniquet system (Zimmer1200)	EQ240													
102	camera, digital (6 mexapixel)	ED004		5		5		5							

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
1	**AMA Specialty Society RVS Update Committee Recommendati**																
2				**P34**		**P42**		**P49**		**P25**		**P68**		**P77**		**P88**	
3	**Meeting Date: Jan/Feb 2009**			**24075**		**25075**		**26115**		**23075**		**27327**		**27618**		**28045**	
4				Upper arm / elbow; subcut; < 3cm		Forearm/Wrist; subcut; < 3cm		Hand/Finger; subcut; < 1.5 cm		Shoulder; subcut; < 3cm		Thigh/Knee, subcut, < 3cm		Leg/Ankle, subcut, < 3cm		Foot/Toe, SUBFASC < 1.5cm	
5	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**	**Office**	**Facility**
6	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**158**	**129**	**158**	**129**	**158**	**129**	**158**	**129**	**158**	**129**	**158**	**129**	**200**	**156**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**	**35**	**60**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**6**	**60**	**6**	**60**	**6**	**60**	**6**	**60**	**6**	**60**	**6**	**75**	**6**
10	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**90**	**90**
11	**PRE-SERVICE**																
12	**Start: Following visit when decision for surgery or procedure made**																
13	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
14	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**
15	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**		**8**		**8**		**8**		**8**		**8**		**8**
16	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**	**10**	**20**
17	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**	**10**	**7**
18	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA														
19	**End:When patient enters office/facility for surgery/procedure**																
20	**SERVICE PERIOD**																
21	**Start: When patient enters site for procedure: Services Prior to Procedure**																
22	Greet patient and provide gowning	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**		**3**	
23	Obtain vital signs	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**		**3**	
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**		**2**		**2**		**2**		**2**		**2**		**2**	
25	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**		**2**		**2**		**2**		**2**		**2**		**2**	
26	**Intra-service**																
27	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**30**		**30**		**30**		**30**		**30**		**30**		**45**	
28	**Post-Service**																
29	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**1**		**1**		**1**		**1**		**1**		**1**		**1**	
30	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**		**3**	
31	Clean Scope	**L037D**	RN/LPN/MTA														
32	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**10**		**10**		**10**		**10**		**10**		**10**		**10**	
33	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**		**3**	
34	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA														
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**3**		**3**		**3**		**3**		**3**		**3**		**3**	
36	Discharge day management	**L037D**	RN/LPN/MTA		**6**		**6**		**6**		**6**		**6**		**6**		**6**
37	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA														
38	**End: Patient leaves office**																
39	**POST-SERVICE Period**																
40	**Start: Patient leaves office/facility**																
41	Conduct phone calls/call in prescriptions																
42	*List Number and Level of Office Visits*																
43	99211 16 minutes		16														
44	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**2**
45	99213 36 minutes		36	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
46	99214 53 minutes		53														
47	99215 63 minutes		63														
48	Other																
49	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**63**	**90**	**90**
50	Other:																
51	**End: with la visit before end of global period**																

1136

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
2				P34		P42		P49		P25		P68		P77		P88	
3	**Meeting Date: Jan/Feb 2009**			24075		25075		26115		23075		27327		27618		28045	
4				Upper arm / elbow; subcut; < 3cm		Forearm/Wrist; subcut; < 3cm		Hand/Finger; subcut; < 1.5 cm		Shoulder; subcut; < 3cm		Thigh/Knee, subcut, < 3cm		Leg/Ankle, subcut, < 3cm		Foot/Toe, SUBFASC < 1.5cm	
5	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility
52	MEDICAL SUPPLIES	Code	Unit														
53	pack, minimum multi-specialty visit	SA048	pack	3	2	3	2	3	2	3	2	3	2	3	2	4	3
54	pack, post-op incision care (suture)	SA054	pack	1	1	1	1	1	1	1	1	1	1	1	1	1	1
55	scrub brush (impregnated)	SM023	item	2		2		2		2		2		2		2	
56	mask, surgical	SB033	item	2		2		2		2		2		2		2	
57	gloves, sterile	SB024	pair	2		2		2		2		2		2		2	
58	gown, staff, impervious	SB027	item	2		2		2		2		2		2		2	
59	blade, surgical hair clipper	SF010	item	0.5		0.5						0.5		0.5			
60	povidone surgical scrub (Betadine)	SJ042	ml	10		10		10		10		10		10		10	
61	drape, sterile, for Mayo stand	SB012	item	1		1		1		1		1		1		1	
62	drape, sterile barrier 16in x 29in	SB007	item	1		1		1		1		1		1		1	
63	drape-towel, sterile OR blue (2 pk uou)	SB020	item	1		1		1		1		1		1		2	
64	skin marking pen, sterile (Skin Skribe)	SK075	item	1		1		1		1		1		1		1	
65	drape, sterile, u-shape	SB015	item														
66	arm board	SC003	item	1		1		1									
67	bandage, Esmarch-Martin, sterile 3in X 9ft	SG015	item	1		1		1									
68	tourniquet, ankle, sterile	SD123	item													1	
69	swab-pad, alcohol	SJ053	item	1		1		1		1		2		2		1	
70	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml									10		10		6	
71	bupivacaine 0.5% inj (Marcaine)	SH021	ml	20		20		20		20		10		10		6	
72	needle, 18-27g	SC029	item	1		1		1		1		2		2		1	
73	needle, 30g	SC031	item	2		2		2		2		2		2		2	
74	syringe 10-12ml	SC051	item	2		2		2		2		2		2		2	
75	syringe 50-60ml	SC056	item	1		1		1		1		1		1		1	
76	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1		1		1		1		1		1	
77	underpad 2ft x 3ft (Chux)	SB044	item	1		1		1		2		1		1		1	
78	basin, irrigation	SJ009	item	1		1		1		1		1		1		1	
79	scalpel with blade, surgical (#10-20)	SF033	item	1		1		1		1		1		1		1	
80	suture, nylon, 3-0 to 6-0, c	SF036	item	1		1		1		1		1		1		1	
81	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item	1		1		1		1		1		1		1	
82	cautery, bipolar cord	SF012	item	1		1		1		1		1		1			
83	cautery, bipolar, pencil-handpiece	SF013	item	1		1		1		1		1		1			
84	cautery, monopolar, pencil-handpiece	SF020	item													1	
85	cautery, patient ground pad w-cord	SF021	item	1		1		1		1		1		1		1	
86	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1		1		1		1		1	
87	bacitracin oint (0.9gm uou)	SJ007	item	1		1		1		1		1		1			
88	dressing, 5in x 9in (Xeroform)	SG041	item	1		1		1		1		1		1		1	
89	tape, surgical paper 1in (Micropore)	SG079	inch	12		12		12		12		12		12		6	
90	dressing, 3inx4in (Telfa, Release)	SG035	item	1		1		1		1		1		1			
91	bandage, Kerlix, sterile 4.5in	SG016	item	1		1		1		1		1		1		1	
92	bandage, elastic, self-adherent wrap 1in (Coban)	SG014	item	1		1		1				1		1		1	
93	pack, cleaning, surgical instruments	SA043	pack	1		1		1		1		1		1		1	
94	cup, biopsy-specimen sterile 4oz	SL036	item	1		1		1		1		1		1		1	

1137

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
2				P34		P42		P49		P25		P68		P77		P88	
3	**Meeting Date: Jan/Feb 2009**			24075		25075		26115		23075		27327		27618		28045	
4				Upper arm / elbow; subcut; < 3cm		Forearm/Wrist; subcut; < 3cm		Hand/Finger; subcut; < 1.5 cm		Shoulder; subcut; < 3cm		Thigh/Knee, subcut, < 3cm		Leg/Ankle, subcut, < 3cm		Foot/Toe, SUBFASC < 1.5cm	
5	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility	Office	Facility
95	Equipment	Code															
96	table, power	EF031		123	63	123	63	123	63	123	63	123	63	123	63	165	90
97	light, surgical	EF014		123	63	123	63	123	63	123	63	123	63	123	63	165	90
98	instrument pack, basic ($500-$1499)	EQ137		60		60		60		60		60		60		75	
99	mayo stand	EF015		60		60		60		60		60		60		75	
100	electrocautery-hyfrecator, up to 45 watts	EQ110		60		60		60		60		60		60		75	
101	tourniquet system (Zimmer1200)	EQ240		60		60		60								75	
102	camera, digital (6 mexapixel)	ED004		5		5		5		5		5		5			

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				P2	P8	P14	P20	P26	P35	P43	P50	P59	P69
2	**AMA Specialty Society RVS Update Committee Recommendation**			21012	21552	21931	22903	23071	24071	25071	26111	27043	27337
3				Face/Scalp, subcut, > 2cm	Neck/Thorax, subcut, > 3cm	Back/Flank, subcut, > 3cm	Abdom Wall, subcut, > 3cm	Shoulder; subcut; > 3cm	Upper arm / elbow; subcut; > 3cm	Forearm/Wrist; subcut; > 3cm	Hand/Finger; subcut; > 1.5 cm	Pelvis/Hip, subcut, > 3cm	Thigh/Knee, subcut, > 3cm
4	**LOCATION**	**Code**	**Staff Type**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**
5	**GLOBAL PERIOD**			090	090	090	090	090	090	090	090	090	090
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	129	129	129	129	129	123	129	129	129	129
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	60	60	60	60	60	60	60	60	60	60
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	6	6	6	6	6	0	6	6	6	6
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	63	63	63	63	63	63	63	63	63	63
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	5	5	5	5	5	5	5	5	5	5
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	8	8	8	8	8	8	8	8	8	8
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	7	7	7	7	7	7	7	7	7	7
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	6	6	6	6	6	0	6	6	6	6
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	1	1	1	1	1	1	1	1	1	1
49	99213 36 minutes		36	1	1	1	1	1	1	1	1	1	1
50	99214 53 minutes		53										
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	63	63	63	63	63	63	63	63	63	63
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	2	2	2	2	2	2	2	2	2	2
58	pack, post-op incision care (suture)	**SA054**	**pack**	1	1	1	1	1	1	1	1	1	1
59	**Equipment**	**Code**											
60	table, power	**EF031**		63	63	63	63	63	63	63	63	63	63
61	light, surgical	**EF014**		63	63	63	63	63	63	63	63	63	63

1139

	A	B	C	N	O	P	Q	R	S	T	U	V	W
1				P78	P4	P9	P10	P15	P16	P21	P22	P27	P28
2	**AMA Specialty Society RVS Update**			27632	21014	21556	21554	21932	21933	22900	22901	23076	23073
3	**Committee Recommendation**			Leg/Ankle, subcut, > 3cm	Face/Scalp, subfasc > 2cm	Neck/Thorax, subfasc < 5cm	Neck/Thorax, subfasc > 5cm	Back/Flank, subfasc < 5cm	Back/Flank, subfasc > 5cm	Abdom Wall, subfasc < 5cm	Abdom Wall, subfasc > 5cm	Shoulder; subfascial; < 5cm	Shoulder; subfascial; > 5cm
4	**LOCATION**	**Code**	**Staff Type**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**129**	**165**	**165**	**171**	**162**	**171**	**162**	**162**	**165**	**171**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**6**	**6**	**6**	**12**	**12**	**12**	**12**	**12**	**6**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**63**	**99**	**99**	**99**	**90**	**99**	**90**	**90**	**99**	**99**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	**6**	**6**	**6**	**12**	**12**	**12**	**12**	**12**	**6**	**12**
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	**1**	**1**	**1**	**1**	**2**	**1**	**2**	**2**	**1**	**1**
49	99213 36 minutes		36	**1**	**2**	**2**	**2**	**1**	**2**	**1**	**1**	**2**	**2**
50	99214 53 minutes		53										
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**63**	**99**	**99**	**99**	**90**	**99**	**90**	**90**	**99**	**99**
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
58	pack, post-op incision care (suture)	**SA054**	**pack**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
59	**Equipment**	**Code**											
60	table, power	**EF031**		**63**	**99**	**99**	**99**	**90**	**99**	**90**	**90**	**99**	**99**
61	light, surgical	**EF014**		**63**	**99**	**99**	**99**	**90**	**99**	**90**	**90**	**99**	**99**

	A	B	C	X	Y	Z	AA	AB	AC	AD	AE	AF	AG
1				P36	P37	P44	P45	P51	P52	P60	P61	P70	P71
2	**AMA Specialty Society RVS Update**			24076	24073	25076	25073	26116	26113	27048	27045	27328	27339
3	**Committee Recommendation**			Upper arm / elbow; subfasc; < 5cm	Upper arm / elbow; subfasc; > 5cm	Forearm/Wrist; subfasc; < 3 cm	Forearm/Wrist; subfasc; > 3 cm	Hand/Finger; subfasc; < 1.5 cm	Hand/Finger; subfasc; > 1.5 cm	Pelvis/Hip, subfasc < 5cm	Pelvis/Hip, subfasc > 5cm	Thigh/Knee, subfasc < 5cm	Thigh/Knee, subfasc > 5cm
4	**LOCATION**	**Code**	**Staff Type**	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only
5	**GLOBAL PERIOD**			090	090	090	090	090	090	090	090	090	090
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	165	165	165	165	165	165	162	171	162	171
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	60	60	60	60	60	60	60	60	60	60
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	6	6	6	6	6	6	12	12	12	12
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	99	99	99	99	99	99	90	99	90	99
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	5	5	5	5	5	5	5	5	5	5
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	8	8	8	8	8	8	8	8	8	8
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	7	7	7	7	7	7	7	7	7	7
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	6	6	6	6	6	6	12	12	12	12
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	1	1	1	1	1	1	2	1	2	1
49	99213 36 minutes		36	2	2	2	2	2	2	1	2	1	2
50	99214 53 minutes		53										
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	99	99	99	99	99	99	90	99	90	99
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	3	3	3	3	3	3	3	3	3	3
58	pack, post-op incision care (suture)	**SA054**	**pack**	1	1	1	1	1	1	1	1	1	1
59	**Equipment**	**Code**											
60	table, power	**EF031**		99	99	99	99	99	99	90	99	90	99
61	light, surgical	**EF014**		99	99	99	99	99	99	90	99	90	99

1141

	A	B	C	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
1				P79	P80	P89	P5	P6	P11	P12	P17	P18	P23
2	**AMA Specialty Society RVS Update Committee Recommendation**			27619	27634	28041	21015	21016	21557	21558	21935	21936	22904
3				Leg/Ankle, subfasc < 5cm	Leg/Ankle, subfasc > 5cm	Foot/Toe, subfasc > 1.5cm	Face/Scalp, radical < 2cm	Face/Scalp, radical > 2cm	Neck/Thorax, radical < 5cm	Neck/Thorax, radical > 5cm	Back/Flank, radical < 5cm	Back/Flank, radical > 5cm	Abdom Wall, radical < 5cm
4	**LOCATION**	**Code**	**Staff Type**	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only
5	**GLOBAL PERIOD**			090	090	090	090	090	090	090	090	090	090
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	156	171	165	201	224	207	224	207	224	207
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	60	60	60	60	60	60	60	60	60	60
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	6	12	6	6	12	12	12	12	12	12
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	90	99	99	135	152	135	152	135	152	135
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	5	5	5	5	5	5	5	5	5	5
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	8	8	8	8	8	8	8	8	8	8
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	7	7	7	7	7	7	7	7	7	7
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	6	12	6	6	12	12	12	12	12	12
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	2	1	1	1	1	1	1	1	1	1
49	99213 36 minutes		36	1	2	2	3	2	3	2	3	2	3
50	99214 53 minutes		53					1		1		1	
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	90	99	99	135	152	135	152	135	152	135
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	3	3	3	4	4	4	4	4	4	4
58	pack, post-op incision care (suture)	**SA054**	**pack**	1	1	1	1	1	1	1	1	1	1
59	**Equipment**	**Code**											
60	table, power	**EF031**		90	99	99	135	152	135	152	135	152	135
61	light, surgical	**EF014**		90	99	99	135	152	135	152	135	152	135

1142

	A	B	C	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA
1				P24	P29	P30	P38	P39	P46	P47	P53	P54	P62
2	**AMA Specialty Society RVS Update**			22905	23077	23078	24077	24079	25077	25078	26117	26118	27049
3	**Committee Recommendation**			Abdom Wall, radical > 5cm	Shoulder; radical; < 5cm	Shoulder; radical; > 5cm	Upper arm / elbow; radical < 5cm	Upper arm / elbow; radical > 5cm	Forearm/Wrist; radical; < 3 cm	Forearm/Wrist; radical; > 3 cm	Hand/Finger; radical; < 3 cm	Hand/Finger; radical; > 3 cm	Pelvis/Hip, radical < 5cm
4	**LOCATION**	**Code**	**Staff Type**	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only	FAC only
5	**GLOBAL PERIOD**			090	090	090	090	090	090	090	090	090	090
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	224	207	224	207	224	207	224	201	251	207
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	60	60	60	60	60	60	60	60	60	60
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	12	12	12	12	12	12	12	6	12	12
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	152	135	152	135	152	135	152	135	179	135
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	5	5	5	5	5	5	5	5	5	5
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	8	8	8	8	8	8	8	8	8	8
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	20	20	20	20	20	20	20	20	20	20
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	7	7	7	7	7	7	7	7	7	7
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	12	12	12	12	12	12	12	6	12	12
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	1	1	1	1	1	1	1	1	2	1
49	99213 36 minutes		36	2	3	2	3	2	3	2	3	2	3
50	99214 53 minutes		53	1		1		1		1		1	
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	152	135	152	135	152	135	152	135	179	135
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	4	4	4	4	4	4	4	4	5	4
58	pack, post-op incision care (suture)	**SA054**	**pack**	1	1	1	1	1	1	1	1	1	1
59	**Equipment**	**Code**											
60	table, power	**EF031**		152	135	152	135	152	135	152	135	179	135
61	light, surgical	**EF014**		152	135	152	135	152	135	152	135	179	135

1143

	A	B	C	BB	BC	BD	BE	BF	BG	BH
1				P63	P72	P73	P75	P76	P84	P85
2	**AMA Specialty Society RVS Update**			27059	27329	27364	27615	27616	28046	28047
3	**Committee Recommendation**			Pelvis/Hip, radical > 5cm	Thigh/Knee, radical < 5cm	Thigh/Knee, radical > 5cm	Leg/Ankle, radical < 5cm	Leg/Ankle, radical > 5cm	Foot/Toe, radical < 3cm	Foot/Toe, radical > 3cm
4	**LOCATION**	**Code**	**Staff Type**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**224**	**207**	**224**	**207**	**224**	**207**	**224**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**60**	**60**	**60**	**60**	**60**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**12**	**12**	**12**	**12**	**12**	**12**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**152**	**135**	**152**	**135**	**152**	**135**	**152**
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**
18	**End:When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
20	**Start: When patient enters site for procedure: Services Prior to Procedure**									
39	Discharge day management	**L037D**	RN/LPN/MTA	**12**	**12**	**12**	**12**	**12**	**12**	**12**
41	**End: Patient leaves office**									
42	**POST-SERVICE Period**									
43	**Start: Patient leaves office/facility**									
46	*List Number and Level of Office Visits*									
47	99211 16 minutes		16							
48	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**
49	99213 36 minutes		36	**2**	**3**	**2**	**3**	**2**	**3**	**2**
50	99214 53 minutes		53	**1**		**1**		**1**		**1**
51	99215 63 minutes		63							
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**152**	**135**	**152**	**135**	**152**	**135**	**152**
55	**End: with last office visit before end of global period**									
56	**MEDICAL SUPPLIES**	**Code**	**Unit**							
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**4**	**4**	**4**	**4**	**4**	**4**	**4**
58	pack, post-op incision care (suture)	**SA054**	**pack**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
59	**Equipment**	**Code**								
60	table, power	**EF031**		**152**	**135**	**152**	**135**	**152**	**135**	**152**
61	light, surgical	**EF014**		**152**	**135**	**152**	**135**	**152**	**135**	**152**

Codes to Price in Office (Non-Facility) Setting

CPT	Descriptor	2009	ID	CPT	Descriptor		2010
SUBCUTANEOUS							
NEW		new	P1	210X1	Face/Scalp, subcut, < 2cm	A 35-ye	yes
			P2	210X2	Face/Scalp, subcut, > 2cm	A 35-ye	no
21555	Neck/Thorax, subcut - any size	yes 25%	P7	215X0	Neck/Thorax, subcut, < 3cm	A 25-ye	yes
			P8	215X1	Neck/Thorax, subcut, > 3cm	A 30-ye	no
21930	Back/Flank, subcut/fasc - any size	yes 23%	P13	21930	Back/Flank, subcut, < 3cm	A 40-ye	yes
			P14	219X1	Back/Flank, subcut, > 3cm	A 50-ye	no
NEW		new	P19	229X0	Abdom Wall, subcut, < 3cm	A 40-ye	yes
			P20	229X1	Abdom Wall, subcut, > 3cm	A 50-ye	no
23075	Shoulder; subcut - any size	yes 19%	P25	230X0	Shoulder; subcut; < 3cm	A 56-ye	yes
			P26	230X1	Shoulder; subcut; > 3cm	A 43 ye	no
24075	Upper arm / elbow; subcut - any size	yes 23%	P34	240X0	Upper arm / elbow; subcut; < 3cm	A 50-ye	yes
			P35	240X1	Upper arm / elbow; subcut; > 3cm	A 50-ye	no
25075	Forearm/Wrist; subcut - any size	yes 23%	P42	250X0	Forearm/Wrist; subcut; < 3cm	A 50-ye	yes
			P43	250X1	Forearm/Wrist; subcut; > 3cm	A 50-ye	no
26115	Hand/Finger; subcut - any size	yes 15%	P49	261X0	Hand/Finger; subcut; < 1.5 cm	A 45-ye	yes
			P50	261X1	Hand/Finger; subcut; > 1.5 cm	A 45-ye	no
27047	Pelvis/Hip, subcut - any size	yes 13%	P58	270X0	Pelvis/Hip, subcut, < 3cm	A 35-ye	yes
			P59	270X1	Pelvis/Hip, subcut, > 3cm	A 42-ye	no
27327	Thigh/Knee, subcut - any size	yes 16%	P68	273X0	Thigh/Knee, subcut, < 3cm	A 38-ye	yes
			P69	273X1	Thigh/Knee, subcut, > 3cm	A 45-ye	no
27618	Leg/Ankle, subcut - any size	yes 21%	P77	276X0	Leg/Ankle, subcut, < 3cm	A 36-ye	yes
			P78	276X1	Leg/Ankle, subcut, > 3cm	A 40-ye	no
28043	Foot/Toe, subcut - any size	yes 43%	P86	280X0	Foot/Toe, subcut, < 1.5cm	A 60-ye	yes
			P87	280X1	Foot/Toe, subcut, > 1.5cm	A 60-ye	yes
SUBFASCIAL							
NEW		new	P3	210X3	Face/Scalp, subfasc < 2cm	A 35-ye	yes
			P4	210X4	Face/Scalp, subfasc > 2cm	A 50-ye	no
21556	Neck/Thorax, subfasc - any size	no	P9	215X2	Neck/Thorax, subfasc < 5cm	A 45-ye	no
			P10	215X3	Neck/Thorax, subfasc > 5cm	A 45-ye	no
NEW		new	P15	219X2	Back/Flank, subfasc < 5cm	A 60-ye	no
			P16	219X3	Back/Flank, subfasc > 5cm	A 60-ye	no
22900	Abdom Wall, subfasc - any size	no	P21	22900	Abdom Wall, subfasc < 5cm	A 40-ye	no
			P22	229X2	Abdom Wall, subfasc > 5cm	A 35-ye	no
23076	Shoulder; subfasc - any size	no	P27	230X2	Shoulder; subfascial; < 5cm	A 47-ye	no
			P28	230X3	Shoulder; subfascial; > 5cm	A 47-ye	no
24076	Upper arm / elbow; subfasc - any size	no	P36	240X2	Upper arm / elbow; subfasc; < 5cm	A 57-ye	no
			P37	240X3	Upper arm / elbow; subfasc; > 5cm	A 57-ye	no
25076	Forearm/Wrist; subfasc - any size	no	P44	250X2	Forearm/Wrist; subfasc; < 3 cm	A 43-ye	no
			P45	250X3	Forearm/Wrist; subfasc; > 3 cm	A 43-ye	no
26116	Hand/Finger; subfasc - any size	no	P51	261X2	Hand/Finger; subfasc; < 1.5 cm	A 35-ye	no
			P52	261X3	Hand/Finger; subfasc; > 1.5 cm	A 35-ye	no
27048	Pelvis/Hip, subfasc - any size	no	P60	270X2	Pelvis/Hip, subfasc < 5cm	A 68-ye	no
			P61	270X3	Pelvis/Hip, subfasc > 5cm	A 68-ye	no
27328	Thigh/Knee, subfasc - any size	no	P70	273X2	Thigh/Knee, subfasc < 5cm	A 39-ye	no
			P71	273X3	Thigh/Knee, subfasc > 5cm	A 39-ye	no
27619	Leg/Ankle, subfasc - any size	yes 7%	P79	276X2	Leg/Ankle, subfasc < 5cm	A 71-ye	no
			P80	276X3	Leg/Ankle, subfasc > 5cm	A 71-ye	no
28045	Foot/Toe, subfasc - any size	yes 21%	P88	280X2	Foot/Toe, subfasc < 1.5cm	A 62-ye	yes
			P89	280X3	Foot/Toe, subfasc > 1.5cm	A 62-ye	no
RADICAL							
21015	Face/Scalp, radical - any size	no	P5	21015	Face/Scalp, radical < 2cm	A 45-ye	no
			P6	210X5	Face/Scalp, radical > 2cm	A 45-ye	no
21557	Neck/Thorax, radical - any size	no	P11	21557	Neck/Thorax, radical < 5cm	A 47-ye	no
			P12	215X4	Neck/Thorax, radical > 5cm	A 47-ye	no
21935	Back/Flank, radical - any size	no	P17	21935	Back/Flank, radical < 5cm	A 60-ye	no
			P18	219X4	Back/Flank, radical > 5cm	A 60-ye	no
NEW		new	P23	229X3	Abdom Wall, radical < 5cm	A 40-ye	no
			P24	229X4	Abdom Wall, radical > 5cm	A 40-ye	no
23077	Shoulder; radical - any size	no	P29	23077	Shoulder; radical; < 5cm	A 40-ye	no
			P30	230X4	Shoulder; radical; > 5cm	A 40-ye	no
24077	Upper arm / elbow; radical - any size	no	P38	240X4	Upper arm / elbow; radical < 5cm	A 50-ye	no
			P39	240X5	Upper arm / elbow; radical > 5cm	A 50-ye	no
25077	Forearm/Wrist; radical - any size	no	P46	25077	Forearm/Wrist; radical; < 3 cm	A 30-ye	no
			P47	250X4	Forearm/Wrist; radical; > 3 cm	A 30-ye	no
26117	Hand/Finger; radical - any size	no	P53	26117	Hand/Finger; radical; < 3 cm	A 20-ye	no
			P54	261X4	Hand/Finger; radical; > 3 cm	A 20-ye	no
27049	Pelvis/Hip, radical - any size	no	P62	270X4	Pelvis/Hip, radical < 5cm	A 65-ye	no
			P63	270X5	Pelvis/Hip, radical > 5cm	A 65-ye	no
27329	Thigh/Knee, radical - any size	no	P72	273X4	Thigh/Knee, radical < 5cm	A 50-ye	no
			P73	273X5	Thigh/Knee, radical > 5cm	A 50-ye	no
27615	Leg/Ankle, radical - any size	no	P75	27615	Leg/Ankle, radical < 5cm	A 45-ye	no
			P76	2761X	Leg/Ankle, radical > 5cm	A 45-ye	no
28046	Foot/Toe, radical - any size	yes 12%	P84	28046	Foot/Toe, radical < 3cm	A 25-ye	no
			P85	2804X	Foot/Toe, radical > 3cm	A 25-ye	no

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five-Year Review
February 2009

Bone Tumors

The American Academy of Orthopaedic Surgery (AAOS) and the Musculoskeletal Tumor Society (MSTS) responded to the Centers for Medicare and Medicaid Services' (CMS) Five-Year Review request for comment on misvalued codes in 1995, arguing that the Hsaio survey had misvalued these services. During the course of this first Five-Year Review process, it became evident that coding changes would be necessary prior to revaluing these services. From 1995-2005, MSTS and AAOS drafted CPT proposals to address issues within the soft tissue tumor excision family and bone tumor family codes but these proposals were rejected by the CPT advisors and/or the CPT Editorial Panel. For the 2005 Five-Year Review, MSTS and AAOS submitted 14 soft tissue tumor codes and 12 bone tumor codes which were ultimately referred again to the CPT Editorial Panel for clarification and creation of new codes to differentiate the codes based on the size and depth of the tumor. In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and BoneWorkgroup which revised and expanded the soft tissue tumor and bone tumor sections to more accurately describe the services being provided and address the concerns raised by the RUC during the Third Five-Year Review.

1150

There are currently 20 codes that describe bone tumor codes. All of these codes were part of the one or more Five-Year Review processes. Between 60-100 musculoskeletal orthopaedic surgeons and orthopaedic surgeons, hand surgeons, podiatrists and foot and ankle surgeons participated in all or some of the surveys. After the results of these providers were tabulated, the associated specialty societies met to discuss the data. The societies presented and the RUC agreed that there is significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence is that there is evidence that technology has changed the physician work as over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Further, for malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This advancement has allowed for increased ability to eradicate tumors in situ at a higher level. While 20 years ago amputation was used most commonly to treat these patients, limb preservation resections have now become the standard treatment of care as currently less than 5% of patients with pelvic and extremity sarcomas receiving amputations. The specialty societies argued and the RUC agreed that the work associated with bone resection procedures has increased dramatically as these procedures are now more technically demanding, prolonged and involve additional risk.

Pelvis

The RUC reviewed the specialty societies' survey results for the eight pelvis radical resection of tumor codes. The specialty societies indicated and the RUC agreed that 10 years ago patients would undergo total leg amputation in cases of bone sarcomas of the pelvis, whereas now limb salvage is an option. The typical pelvis radical resection of tumor patient is usually in the hospital for 7-10 days.

27077

The RUC reviewed the pelvis anchor codes starting with the largest, most complex procedure of this family, code 27077 *Radical resection of tumor; innominate bone, total.* The RUC reviewed the pre-service time and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC compared 27077 to key reference service 20956 *Bone graft with microvascular anastomosis; iliac crest* (work RVU = 40.93, intraservice time 400 minutes) and determined that the survey median physician time of 400 minutes and work RVU of 45.00 appropriately accounted for the physician time and work required to perform this service and placed this service in the proper rank order. The RUC noted that the survey respondents indicated that 27077 was much more intense than 20956. The RUC further supported a work RVU of 45.00 for 27077 by comparing it to similar service, 20973 *Free osteocutaneous flap with microvascular anastomosis; great toe with web space* (work RVU = 46.95).

1151

The specialty societies indicated and the RUC agreed that four 99231 and four 99232 hospital visits are typical as patients are usually in the hospital for 7-10 days and since limb salvage is possible the patient will need that time to recover in the hospital. The specialty societies also indicated and the RUC agreed that one higher level office visit, 99214, was appropriate as the physician will perform an extensive consultation, review of pathology margins, contact 2-3 consulting physicians, oncologists or radiation oncologists and the visit will last one hour to 1.5 hours. Patients typically have sarcomas and aggressive cancer and a 99214 allows for extensive treatment plans. Additionally the RUC determined that 2-99213 office visits are appropriate because typically these extremity related events require significant physical therapy, joint stability examination and range of motion checks. **The RUC recommends the survey median work RVU of 45.00 for code 27077.**

27076

The RUC reviewed code 27076 *Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum* and agreed with the specialty societies that there has been a long standing rank order anomaly between codes 27076 and 27077 (approximately 22.00 difference in RVUs). The RUC reviewed the pre-time and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the

pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC determined that 27076 required slightly less physician intra-service time than 27077 (360 versus 400, respectively). However, 27076 is slightly more intense than 27077 because of the location and size of large the tumors typically surrounding the areas of the pelvis being removed in this procedure. The RUC compared code 27076 to 27077 and key reference service 20956 *Bone graft with microvascular anastomosis; iliac crest* (work RVU = 40.93, intraservice time 400 minutes). The RUC noted the survey respondents indicated that 27076 is more intense and complex than 20956. Even though the intra-service time is longer for reference service 20956, more mental effort, technical skill and psychological stress is exerted or occurs when performing 27076. The RUC determined that the survey median physician time of 360 minutes and work RVU of 40.00 appropriately accounted for the physician time and work required to perform this service and placed this service in the proper rank order. The RUC agreed with the specialty societies and recommends one less 99231 hospital visit for 27076 than 27077. **The RUC recommends the survey median work RVU of 40.00 for 27076.**

27075

The RUC reviewed code 27075 *Radical resection of tumor; wing of ilium, one pubic or ischial ramus or symphysis pubis* and determined that the physician time and work required will be significantly less than 27076 and 27077 as this procedure is the removal of one portion of the pelvis. Additionally, 27075 requires fewer hospital visits (2-99231 and 3-99232 visits) than 27076 and 27077. The RUC reviewed the pre-time and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as the typically the patient is in the supine position for this procedure. The RUC compared code 27075 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time required to perform 27075 is slightly more than 270134. The survey respondents also responded that 27075 is more intense and complex than 27134. The RUC determined that a work RVU of 32.50 for 27075 appropriately places this service in the proper rank order within this family of services. **The RUC recommends the survey median work RVU of 32.50 for 27075.**

27078

The RUC reviewed 27078 *Radical resection of tumor; ischial tuberosity and greater trochanter of femur* and determined that the physician time, work and intensity required is similar to 27075. The RUC reviewed the pre-time and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordinate with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone position after anesthesia is administered. The RUC compared code 27078 to 27075 and to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or*

allograft (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician intra-service time required to perform these services is the same and the physician work and intensity required is similar. Additionally, 27078 requires the same number of hospital and office visits as 27075. **The RUC recommends the survey median work RVU of 32.00 for 27078.**

Upper Limb

The RUC reviewed the upper limb radical resection of tumor codes. The specialty societies indicated that most patients receiving these procedures have had pre-operative chemotherapy and are catabolic and may have sarcomas pressing on the aortic arch and subclavian. The physician must carefully identify the soft tissue mass as not to damage surrounding viable tissue. Thus, the closer the tumor is to the shoulder the more complex the procedure. The specialty societies indicated that one 99214 office visit is required for each upper limb radical resection of bone tumor codes. The RUC agreed that the number of office visits were appropriate as the physician will discuss pathology, coordinate care, and assess functional rehabilitation and physical therapy.

23200

The RUC reviewed the pre-service time for code 23200 *Radical resection of tumor; clavicle* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the lateral position. The RUC then compared 23200 to key reference service 27447 Arthroplasty, *knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 23.04, intra-service time = 124 minutes) and determined that the physician time and intensity was slightly higher for code 23200. The RUC determined the survey median work RVU of 22.50 and median physician time of 155 minutes appropriately places this service in the proper rank order within this family of services. **The RUC recommends the survey median work RVU 22.50 for 23200.**

23210

The RUC reviewed the pre-service time for code 23210 *Radical resection of tumor; scapula* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone or lateral position. The RUC then compared 23210 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time, work and intensity was slightly lower for code 23210. The RUC noted that the 23210 has a slightly lower work RVU than 27134, as it has a shorter length of stay requiring only one 99231. The RUC

determined the survey 25th percentile work RVU of 27.00 and median intra-service time of 210 minutes appropriately placed 23210 in relativity to 27134. **The RUC recommends the survey 25th percentile work RVU of 27.00 for 23210.**

23220

The RUC reviewed the pre-service time for code 23220 *Radical resection of tumor; proximal humerus* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the lateral position. The RUC then compared 23220 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time, work and intensity was the same for these procedures. The RUC determined the survey 25th percentile work RVU of 30.00 and median physician time of 240 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU of 30.00 for 23220.**

24150

The RUC reviewed the pre-service time for code 24150 *Radical resection of tumor; shaft or distal humerus* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and position the arm and hand correctly. The RUC then compared 24150 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity was the similar for these procedures. The RUC agreed that the survey median work RVU of 23.25 and median physician time of 180 minutes was appropriate to perform this service. **The RUC recommends the survey median work RVU of 23.25 for 24150.**

24152

The RUC reviewed the pre-service time for code 24152 *Radical resection of tumor; radial head or neck* and agreed with the specialty societies that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 24152 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity was the similar for these procedures. The RUC determined the survey 25th percentile work RVU of 19.78 and median physician time of 150 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU of 19.78 for 24152.**

25170
The RUC reviewed the pre-service time for code 24170 *Radical resection of tumor; radius or ulna* and agreed with the specialty societies that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 24170 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity is similar for these procedures. The RUC agreed the survey median work RVU of 22.00 and similar total physician time indicates that the work for these two services are the same. **The RUC recommends the survey median work RVU of 22.00 for 25170.**

26250
The RUC reviewed the pre-service time for code 26250 *Radical resection of tumor; metacarpal* and agreed with the specialty societies that pre-time package 2b – Difficult Patient/Straightforward Procedure was appropriate. The specialty societies indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 10 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 26250 to key reference service 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU = 10.95, intra-service time = 100 minutes) and determined that the physician time, work and intensity is higher for 26250. To further support the survey median work RVU of 15.00, the RUC compared 26250 to 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)* (work RVU = 14.97, intra-service time = 120 minutes), which requires similar physician work and intra-service time. The RUC determined the survey median work RVU of 15.00 and median physician time of 120 minutes was appropriate to perform this service. **The RUC recommends the survey median work RVU of 15.00 for 26250.**

26260
The RUC reviewed the pre-service time for code 26260 *Radical resection of tumor; proximal or middle phalanx of finger* and agreed with the specialty societies that pre-time package 2b – Difficult Patient/Straightforward Procedure was appropriate. The specialty societies indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 10 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 26260 to key reference service 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU =

10.95, intra-service time = 100 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey 25th percentile work RVU of 11.00 and median physician time of 90 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU 11.00 for 26260.**

26262

The RUC reviewed the pre-service time for code 26262 *Radical resection of tumor; distal phalanx of finger* and agreed with the specialty societies that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The specialty societies indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 5 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC agreed that in cases with a malignant bone tumor of the finger, it is usually amputated, but in some cases the thumb may be preserved. The RUC then compared 26262 to key reference service 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU = 8.21, intra-service time = 60 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC compared 26262 to code 28175 *Radical resection of tumor; phalanx of the toe* and to avoid a rank order anomaly the RUC agreed that the 25th percentile work RVU for of 8.13 for 28175 is appropriate for 26262 as it is similar to the survey 25th percentile work RVU of 8.00. The RUC determined that a work RVU of 8.13 and physician time of 60 minutes is appropriate to perform the work required for this procedure. **The RUC recommends a work RVU of 8.13 for 26262.**

1156

Lower Limb

The RUC reviewed the specialty societies' survey results for the lower limb radical resection of tumor codes. The specialty societies indicated now, as opposed to 10 years ago, most patients will receive a total femoral replacement instead of amputation. The typical Medicare patient population may have more metastatic disease of the distal femur or renal cell carcinoma. Patients are typically in the hospital for a week. The lower limb radical resection procedures have similar intensity to the pelvis iliac wing resection, code 27075, but are not as high as the total pelvis resection or pelvis and acetabulum resections 27077 or 27076. The specialty societies indicated that one 99214 office visit is required for each lower limb radical resection of bone tumor codes. The RUC agreed that the number of office visits were appropriate as the physician will discuss pathology, coordinate care, and assess functional rehabilitation and physical therapy.

27365
The RUC reviewed the pre-service time for code 27365 *Radical resection of tumor; femur or knee* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as typically the patient is in the supine position for this procedure. The RUC then compared code 27365 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time required to perform these services is exactly the same and the work required is slightly more intense for 27365. Additionally, the RUC compared 27365 to 27078 and agreed these services are similar, both requiring the same intra-operative time of 240 minutes. However, 27365 is slightly more intense intra-operatively because for this procedure the physician typically must carefully isolate and immobilize the popliteal and femoral arteries. Additionally, 27365 requires the same number of hospital and office visits as 27078. **The RUC recommends the survey median work RVU of 32.00 for 27365.**

27645
The RUC reviewed code 27645 *Radical resection of tumor; tibia* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as the typically the patient is in the supine position for this procedure. The RUC then compared code 27645 to key reference service 27156 *Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip* (work RVU = 26.03, intra-service time = 225 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey median work RVU of 27.00 and median physician time of 200 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends a work RVU of 27.00 for 27645.**

27646
The RUC reviewed 27646 *Radical resection of tumor; fibula* and agreed with the specialty societies that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC then compared code 27646 to key reference service 27447 Arthroplasty, *knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 23.04, intra-service time = 124 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey median and 25th percentile work RVU of 23.00 and median physician time of 180 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends the survey median work RVU of 23.00 for 27646.**

27647

The RUC reviewed code 27647 *Radical resection of tumor; talus or calcaneus* and agreed with the specialty societies that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 10 minutes of pre-evaluation time was appropriate for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with the reconstructive surgeon. The RUC also determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone position after anesthesia is administered. The RUC then compared code 27647 to key reference service 27580 *Arthrodesis, knee, any technique* (work RVU = 20.90, intra-service time = 150 minutes) and determined the physician time, work and intensity is similar for these services. The RUC determined the survey median work RVU of 20.10 and median physician time of 144 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends the survey median work RVU of 20.10 for 27647.**

28171

The RUC reviewed code 28171 *Radical resection of tumor; tarsal (except talus or calcaneus)* and agreed with the specialty societies that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 10 minutes of pre-evaluation time was appropriate for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with the reconstructive surgeon. The RUC also determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC then compared code 28171 to key reference service 27580 *Arthrodesis, knee, any technique* (work RVU = 20.90, intra-service time = 150 minutes) and determined the physician time, work and intensity is slightly lower for 28171. To further support the survey 25th percentile work RVU of 16.25, the RUC compared 28171 to 28415 *Open treatment of calcaneal fracture, includes internal fixation, when performed* (work RVU = 15.96, intra-service time = 120 minutes), which requires similar physician work and intra-service time. The RUC determined the survey 25th percentile work RVU of 16.25 and median physician time of 120 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services and reference service. **The RUC recommends the survey 25th percentile work RVU of 16.25 for 28171.**

28173

The RUC reviewed code 28173 *Radical resection of tumor; metatarsal* and agreed with the specialty societies that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The RUC determined that an additional 2 minutes of pre-positioning time is required to elevate the patient's leg, stabilize the foot and pad the opposite extremity. The RUC then compared code 28173 to key reference service 28715 *Arthrodesis; triple* (work RVU = 14.40 intra-service time = 130 minutes) and determined the physician time, work and intensity is similar for these services. The RUC determined the survey 25th percentile work RVU of 14.00 and median physician time of 110 minutes appropriately places this procedure in the proper rank order with the other lower limb

radical tumor resection services and reference service. **The RUC recommends the survey 25th percentile work RVU of 14.00 for 28173.**

28175

The RUC reviewed code 28175 *Radical resection of tumor; phalanx of toe* and agreed with the specialty societies that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The RUC determined that an additional 2 minutes of pre-positioning time is required to elevate the patient's leg and stabilize the foot. The RUC then compared code 28175 to 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 intra-service time = 60 minutes) and determined the physician time, work and intensity is similar for these services. To further support the survey 25th percentile work RVU of 8.13, the RUC compared 28175 to 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU = 8.21, intra-service time = 60 minutes), which requires similar physician work and intra-service time.The RUC determined the survey 25th percentile work RVU of 8.13 and median physician time of 60 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. Additionally, the RUC agreed that upper limb radical resection of bone tumor code 26262 is equal to this lower limb resection of bone tumor code 28175. **The RUC recommends the survey 25th percentile work RVU of 8.13 for 28175.**

1159

Practice Expense

The practice expense inputs recommended by the specialty in the facility setting were reviewed and agreed upon. **The RUC recommends the attached standard 090-day direct practice expense inputs.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲23200	P31	Radical resection ~~for~~ of tumor; clavicle	090	22.50
▲23210	P32	scapula	090	27.00
▲23220	P33	Radical resection of ~~bone~~ tumor, proximal humerus;	090	30.00
▲24150	P40	Radical resection ~~for~~ of tumor, shaft or distal humerus;	090	23.25

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲24152	P41	Radical resection ~~for~~ of tumor, radial head or neck~~;~~	090	19.78
▲25170	P48	Radical resection ~~for~~ of tumor, radius or ulna	090	22.00
▲26250	P55	Radical resection of tumor, metacarpal ~~(eg, tumor);~~	090	15.00
▲26260	P56	Radical resection of tumor, proximal or middle phalanx of finger ~~(eg, tumor);~~	090	11.00
▲26262	P57	Radical resection of tumor, distal phalanx of finger (eg, tumor) (26255, 26261 have been deleted)	090	8.13
▲27075	P64	Radical resection of tumor ~~or infection~~; wing of ilium, one pubic or ischial ramus or symphysis pubis	090	32.50
▲27076	P65	ilium, including acetabulum, both pubic rami, or ischium and acetabulum	090	40.00
▲27077	P66	innominate bone, total	090	45.00
▲27078	P67	ischial tuberosity and greater trochanter of femur	090	32.00
D 27079		~~ischial tuberosity and greater trochanter of femur, with skin flaps~~ (27079 has been deleted)	090	N/A
▲27365	P74	Radical resection of tumor, ~~bone,~~ femur or knee	090	32.00
▲27645	P81	Radical resection of tumor~~, bone~~; tibia	090	27.00

1160

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲27646	P82	fibula	090	23.00
▲27647	P83	talus or calcaneus	090	20.10
▲28171	P90	Radical resection of tumor~~, bone~~; tarsal (except talus or calcaneus)	090	16.25
▲28173	P91	metatarsal	090	14.00
▲28175	P92	phalanx of toe	090	8.13

1161

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23200 Tracking Number P31 Specialty Society Recommended RVU: **22.50**

Global Period: 090 RUC Recommended RVU: **22.50**

CPT Descriptor: Radical resection of tumor; clavicle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male presents with an osteosarcoma of the clavicle with its pushing border displacing the subclavian vessels inferiorly. At operation, a radical resection of the clavicle with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 11% , Admitted (more than 24 hours) 89%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

.s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with lateral beach chair positioning, exposing the shoulder and stabilizing the patient's torso. 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: A long incision is made paralleling the clavicle from the midline to the shoulder. The prior biopsy site is ellipsed with the biopsy area staying with the resected specimen. Skin and subcutaneous flaps are developed avoiding entering the tissue plain of the prior biopsy. Deep fascial planes are opened. The brachial plexus is carefully dissected and exposed. The subclavian vein and artery are exposed and dissected away from the tumor. The subclavius muscle stays with the tumor mass about the clavicle. The sterno-clavicular joint is opened and incised. The acromio-clavicular joint is opened and incised. The coracoclavicular ligaments are divided. The strap neck muscles and sternocleidomastoid musculature is divided above the clavicle. The deltoid and pectoralis inferior attachments are divided. The anterior and superior portion first rib region is sacrificed with the adjacent tissue and bony surface going with the tumor specimen to maintain an en bloc tumor resection. During the procedure, preoperative image studies are reviewed to verify intended planes of dissection and proximity of neurovascular bundles. The

specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stabi[redacted] of the patient. In the pathology department, the surgeon then examines the resected specimen with the atten[redacted] pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. Careful homeostasis is obtained and drains are appropriately placed deep in the wound to protect the flaps. A meticulous multilayered wound closure is accomplished.

Description of Post-Service Work: Apply dressings and shoulder immobilizer. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of shoulder immobilizer. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functio[redacted] recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provi[redacted] necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD				
Specialty(s):	MSTS; AAOS				
CPT Code:	23200				
Sample Size:	60	**Resp N:**	28	**Response:** 46.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	15.00
Survey RVW:	20.00	20.00	**22.50**	28.50	35.00
Pre-Service Evaluation Time:			**83.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	90.00	128.00	**155.00**	188.00	300.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23200	**Recommended Physician Work RVU: 22.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**155.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 21.4 **%**

TIME ESTIMATES (Median)	CPT Code: 23200	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	72.00	75.00	
Median Intra-Service Time	155.00	124.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**497.00**	**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	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	3.50
Urgency of medical decision making	4.83	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.00
Physical effort required	4.17	4.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.33
Outcome depends on the skill and judgment of physician	5.00	4.33
Estimated risk of malpractice suit with poor outcome	4.33	4.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.67	3.33
Intra-Service intensity/complexity	4.50	4.00
Post-Service intensity/complexity	4.50	3.83

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.*

ompelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of

these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advance. have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder and stabilizing the patient's torso.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW of 22.50. Along with the recommended time and visit information, this results in an IWPUT of 0.077. This RVW is similar to the reference code 27447, which is also a demanding operation, with significant post service work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unliste. code is reviewed) 23200

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 How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national, non-medicare, frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 36
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 20 Percentage 55.55 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

How 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:23210 Tracking Number P32 Specialty Society Recommended RVU: **27.00**

Global Period: 090 RUC Recommended RVU: **27.00**

CPT Descriptor: Radical resection of tumor; scapula

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with a chondrosarcoma with its pushing border displacing the scapula outward from the chest wall, but not extending into the glenohumeral joint. At operation, a radical resection of the scapula with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. 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: A longitudinal slightly oblique incision is made vertically down and past the distal tip of the scapula. The prior biopsy site is ellipsed with the biopsy area staying with the resected specimen. Skin and subcutaneous flaps are developed avoiding entering the tissue plain of the prior biopsy. Deep fascial planes are opened. The trapezius and levator superiorly and the rhomboids medially are divided. The teres major and minor are divided laterally. The rotator cuff near the proximal humerus is divided after the deltoid is taken off of the acromion. T suprascapular neurovascular bundle is identified and divided. The glenohumeral joint is disarticulated. The serratu anterior is divided with the adjacent tissue going with the tumor specimen to effect an en bloc tumor resection. During the procedure, preoperative image studies are reviewed to verify intended planes of dissection and proximity of neurovascular bundles. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then

breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If all margins appear satisfactory then the surgeon returns to the OR, repeats pre-operative scrub and returns to the surgical field. Careful homeostasis is obtained and drains are appropriately placed deep in the wound to protect the flaps. A meticulous multilayered wound closure is accomplished.

Description of Post-Service Work: Apply dressings and shoulder immobilizer. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of shoulder immobilizer. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD				
Specialty(s):	MSTS; AAOS				
CPT Code:	23210				
Sample Size:	60	**Resp N:**	28	**Response:** 46.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	4.00	15.00
Survey RVW:	23.00	27.00	**30.00**	30.00	45.00
Pre-Service Evaluation Time:			**90.00**		
Pre-Service Positioning Time:			**25.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	110.00	150.00	**210.00**	248.00	480.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23210	**Recommended Physician Work RVU: 27.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**210.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27134	090	27.34	**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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 39.2 %

TIME ESTIMATES (Median)	CPT Code: 23210	Key Reference CPT Code: 27134	Source of Time RUC Time
Median Pre-Service Time	80.00	90.00	
Median Intra-Service Time	210.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**560.00**	**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	4.78	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.78	3.78
Urgency of medical decision making	4.44	3.44

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.67
Physical effort required	4.67	4.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.56
Outcome depends on the skill and judgment of physician	4.89	4.56
Estimated risk of malpractice suit with poor outcome	4.22	4.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.78	3.89
Intra-Service intensity/complexity	5.00	4.56
Post-Service intensity/complexity	4.44	3.67

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of

these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

)ver the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW of 27.00. Along with the recommended time and visit information, this results in an IWPUT of 0.078. This RVW is less than the reference code 27134, which is also a demanding operation that has a greater intra-service time and different, but slightly more post-work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

.ow was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23210

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 How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national, non-medicare, frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 27 Percentage 77.14 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:23220 Tracking Number P33 Specialty Society Recommended RVU: **30.00**

Global Period: 090 RUC Recommended RVU: **30.00**

CPT Descriptor: Radical resection of tumor, proximal humerus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male presents with an osteosarcoma of the proximal humerus with its pushing border displacing the axillary artery and lower brachial plexus and brachial nerves medially. The axillary nerve is intimately involved with the tumor. At operation, a radical resection of the proximal humerus with adjacent soft tissue including the deltoid muscle and axillary nerve is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with lateral beach chair positioning, exposing the shoulder and stabilizing the patient's torso. 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: A longitudinal incision is made from the clavicle over the shoulder down to the 2/3 junction of the distal humerus. The prior biopsy site is ellipsed with the biopsy area staying with the resected specimen. Skin and subcutaneous flaps are developed avoiding entering the tissue plain of the prior biopsy. Deep fascial planes are opened. The brachial plexus is exposed. The subclavian vein and artery are exposed and followed to the axillary region (axillary vein and artery) and are dissected away from the tumor. The deltoid attachments are divided proximally off of the clavicle and acromion or with these bone structures included in the tumor resection. The attachment of the respective muscle groups that make up the rotator cuff (supraspinatus, infraspinatus, subscapular, teres), latissimus dorsi, pectoralis major/minor are divided proximal to the insertion on the humerus away from the tumor mass. The axillary nerve is identified near the plexus and divided. The shoulder joint capsule is divided away from the proximal

humerus. At the mid humeral bony junction, exposure is accomplished without injuring radial, ulnar, median or musculocutaneous nerves. The humerus is divided in the mid shaft area. During the procedure, preoperative image studies are reviewed to verify intended planes of dissection and proximity of neurovascular bundles. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request fo along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. Careful homeostasis is obtained and drains are appropriately placed deep in the wound to protect the flaps. A meticulous multilayered wound closure is accomplished.

Description of Post-Service Work: Apply dressings and shoulder immobilizer. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of shoulder immobilizer. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient wil be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, a redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order an review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD				
Specialty(s):	MSTS; AAOS				
CPT Code:	23220				
Sample Size:	60	**Resp N:**	28	**Response:** 46.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**4.00**	5.00	15.00
Survey RVW:	23.00	30.00	**32.50**	35.00	50.00
Pre-Service Evaluation Time:			**85.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	180.00	**240.00**	255.00	400.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**120.00**	99231x **2.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23220	**Recommended Physician Work RVU: 30.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**120.00**	99231x **2.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 42.8 %

TIME ESTIMATES (Median)	CPT Code: 23220	Key Reference CPT Code: 27134	Source of Time RUC Time
Median Pre-Service Time	72.00	90.00	
Median Intra-Service Time	240.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	120.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**602.00**	**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	4.75	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	4.00
Urgency of medical decision making	4.42	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.56	4.00
Physical effort required	4.42	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.83	4.58
Outcome depends on the skill and judgment of physician	4.50	4.33
Estimated risk of malpractice suit with poor outcome	4.08	4.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.17	4.92
Intra-Service intensity/complexity	4.50	4.67
Post-Service intensity/complexity	4.00	4.00

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder and stabilizing the patient's torso.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW of 30.00. Along with the recommended time and visit information, this results in an IWPUT of 0.078. This RVW is similar to the reference code 27134, which is also a demanding operation, with significant post service work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23220

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 How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national, non-medicare, frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 41
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 38 Percentage 92.68 %

Specialty Frequency 0 Percentage 0.00 %

pecialty 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:24150 Tracking Number P40 Specialty Society Recommended RVU: **23.25**

Global Period: 090 RUC Recommended RVU: **23.25**

CPT Descriptor: Radical resection of tumor, shaft or distal humerus

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male presents with an osteosarcoma in the distal one-third of the humerus with its pushing border displacing the brachial artery and arterial bifurcation anteriorly. At operation, a radical resection of the distal one-third humeral shaft and joint with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 12% , Admitted (more than 24 hours) 88%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made paralleling the length of the arm from the proximal 1/3 to across the antecubital area down into the forearm. The prior biopsy site is ellipsed with the biopsy area staying with the resected specimen. Skin and subcutaneous flaps are developed avoiding entering the tissue plain of the prior biopsy. Deep fascial planes are opened. Median, ulnar, and radial nerves are identified proximally and distally a followed and dissected away from the tumor mass. The brachial vein and artery are exposed and dissected away fro. the tumor. The elbow joint is opened and the capsule is exposed. The midshaft humerus is exposed. Involved muscle groups (biceps, triceps brachialis) are divided proximally and distally to the tumor. Numerous perforating and named vessels are identified and ligated and incised. The shaft of the humerus is osteotomized. During the procedure, preoperative image studies are reviewed to verify intended planes of dissection and proximity of neurovascular bundles.

The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. Careful homeostasis is obtained and drains are appropriately placed deep in the wound to protect the flaps. A meticulous multilayered wound closure is accomplished.

Description of Post-Service Work: Apply dressings and sling. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD		
Specialty(s):	MSTS; AAOS; ASSH		
CPT Code:	24150		
Sample Size:	75	**Resp N:** 27	**Response:** 36.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	15.00
Survey RVW:	14.00	22.00	**23.25**	30.00	45.00
Pre-Service Evaluation Time:			**80.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	150.00	**180.00**	240.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	24150	**Recommended Physician Work RVU: 23.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**80.00**	99231x **2.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24363	090	22.47	RUC Time

CPT Descriptor Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 37.0 %

TIME ESTIMATES (Median)	CPT Code: 24150	Key Reference CPT Code: 24363	Source of Time RUC Time
Median Pre-Service Time	72.00	83.00	
Median Intra-Service Time	180.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**502.00**	**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	4.56	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	3.56
Urgency of medical decision making	4.56	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	3.00
Physical effort required	4.56	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.22	3.78
Outcome depends on the skill and judgment of physician	4.56	3.89
Estimated risk of malpractice suit with poor outcome	4.44	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.44	3.33
Intra-Service intensity/complexity	4.33	3.67
Post-Service intensity/complexity	3.78	3.33

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of

these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW of 23.25. Along with the recommended time and visit information, this results in an IWPUT of 0.074. This RVW is less than the reference code 24363, which is also a demanding operation that has a less intra-service time and similar post-work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

REQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24150

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 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. national, non-medicare, frequency not available

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? 85
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 81 Percentage 95.29 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:24152 Tracking Number P41 Specialty Society Recommended RVU: **19.78**

Global Period: 090 RUC Recommended RVU: **19.78**

CPT Descriptor: Radical resection of tumor, radial head or neck

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with a chondrosarcoma of the proximal radial head and neck with its pushing border displacing the radial nerve and the posterior interosseous nerve. At operation, a radical resection of the proximal radius with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 15% , Admitted (more than 24 hours) 85%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made utilizing a Henry approach extending from above the elbow anteriorly and paralleling the proximal radius anterolaterally. The prior biopsy site is ellipsed with the biopsy area staying with the resected specimen. Skin and subcutaneous flaps are developed avoiding entering the tissue plain of e prior biopsy. Deep fascial planes are opened. The radial nerve is followed proximally down towards the radial ead. The supinator is identified. The posterior interosseous nerve is identified. The brachial artery and vein are identified. The elbow joint is opened and incised. The tissues about the midshaft of the radius are opened and incised. The radial collateral ligament is identified and divided extra-periosteally off of the humeral condylar region. The midshaft interval is identified and the radius is divided. During the procedure, preoperative image studies are reviewed to verify intended planes of dissection and proximity of neurovascular bundles. The specimen is then removed from the

field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathol department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologis the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. Careful homeostasis is obtained and drains are appropriately placed deep in the wound to protect the flaps. A meticulous multilayered wound closure is accomplished.

Description of Post-Service Work: Apply dressings and sling. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordinati telephonic or electronic communication assistance, and other necessary management for reconstruction and furth chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD				
pecialty(s):	MSTS; AAOS; ASSH				
CPT Code:	24152				
Sample Size:	75	**Resp N:**	27	**Response:** 36.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**1.00**	3.00	20.00
Survey RVW:	14.30	19.78	**22.00**	27.38	40.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	100.00	125.00	**150.00**	240.00	300.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	24152	**Recommended Physician Work RVU: 19.78**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**150.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
ischarge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
ffice time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24363	090	22.47	**RUC Time**

CPT Descriptor Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 18.5 %

TIME ESTIMATES (Median)

	CPT Code: 24152	**Key Reference CPT Code: 24363**	**Source of Time RUC Time**
Median Pre-Service Time	60.00	83.00	
Median Intra-Service Time	150.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**440.00**	**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	4.60	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	3.80
Urgency of medical decision making	4.60	3.80

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	3.80
Physical effort required	4.60	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.80	4.00
Outcome depends on the skill and judgment of physician	4.60	4.00
Estimated risk of malpractice suit with poor outcome	4.80	3.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.80	4.00
Intra-Service intensity/complexity	4.80	4.00
Post-Service intensity/complexity	4.60	4.00

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of

these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advance. have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW of 19.78. Along with the recommended time and visit information, this results in an IWPUT of 0.072. This RVW is less than the reference code 24363, which is also a demanding operation with similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24152

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

pecialty 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. national, non-medicare, frequency not available

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? 4
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 4 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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25170 Tracking Number P48 Specialty Society Recommended RVU: **22.00**

Global Period: 090 RUC Recommended RVU: **22.00**

CPT Descriptor: Radical resection of tumor, radius or ulna

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old-male presents with an osteosarcoma of the radius with extension through the interosseous membrane, abutting the ulna, with an associated soft tissue mass extending from the bone. At operation, a radical resection of the radius with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 19% , Admitted (more than 24 hours) 81%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Exsanguinate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made in a longitudinal orientation, ellipsing the biopsy tract in a wide en bloc fashion from the elbow, incorporating the biopsy tract, extending the incision to the wrist. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the forearm, extending down to the wrist. The tumor originates the bone but is associated with a large soft tissue mass that involves the surrounding musculature. The dissectic therefore proceeds through the volar musculature; once again, maintaining a cuff of normal, non-tumor involved muscle on the tumor to maintain a wide margin around the tumor. The flexor carpi radialis and flexor carpi ulnaris, along with the flexor digitorum sublimis and profundus muscles are dissected from the underlying soft tissue component of the bony tumor. The neurovascular bundle, associated with the tumor, is meticulously dissected free from the overlying tumor.

The artery, vein, and nerves are sharply dissected from their sheath maintaining the sheath as a margin on the tumor. The interosseous membrane is approached and identified and then carefully divided in order to mobilize the radius. At this point the dissection is carried over to the dorsal side of the forearm. The same approach is utilized here, dissecting the overlying extensor muscles from the underlying tumor, maintaining a cuff of normal tissue in a wide en bloc fashion. The neurovascular structures here are dissected free from the tumor and maintained to allow functional restoration of the limb. The dissection is carried further distal to the wrist joint. Proximally, the dissection is carried towards the elbow where the joint capsules of both the wrist and elbow are exposed. The remaining capsular structures are then transected being very careful to protect the neurovascular structures (artery, vein, and nerves, both radial and ulna) which lie intimately in contact with the capsular structures. The radius is then elevated forwards to allow for exposure of the forearm. Care is taken to ligate each feeding vessel into the tumor. The dissection is carried proximally in this fashion until the level of the proposed osteotomy dictated by the pre-operative planning is reached. At this point, typically 12 cm. above the wrist, the dissection is carried circumferentially around the entire bone. The bone is then cut with a saw and the remaining soft tissues are dissected free from the specimen. The specimen consists of the skin of the biopsy tract, the underlying subcutaneous fat, fascia, muscle, tumor, bone, ligaments, tendons, and capsular structures, all in one piece, without any contamination of either tumor or prior surgery. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. If positive margins are found, additional resection is required. The wound bed is inspected, bleeding vessels are ligated and the neurovascular structures are re-evaluated to ensure they are intact. During the remainder of the procedure, these structures must be protected from stretch, twisting, retraction, etc. as there is now no bone to provide structure of this limb. The soft tissue reconstruction can be begun once all frozen sections reveal clear margins. Gloves and instruments are changed to prevent any contamination. The muscles are mobilized in order to provide coverage over the remaining bone. The dissection is carried more proximally until the muscles can be rotated to fill in the void left by the tumor. Muscle bellies are repaired to themselves as is the fascia. The fascial layers are closed in a watertight fashion over a drain, followed by closure of the subcutaneous tissues and skin.

Description of Post-Service Work: Apply dressings and sling. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Examine patient, assessing open wound status and drain. Assess neurovascular status. Wound care and close observation are important to avoid or promptly treat compartment syndrome. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent day(s), review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing) and use of sling. Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD		
Specialty(s):	MSTS; AAOS		
CPT Code:	25170		
Sample Size:	75	**Resp N:** 27	**Response:** 36.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	15.00
Survey RVW:	10.00	20.00	**22.00**	29.63	45.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	90.00	120.00	**180.00**	203.00	300.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	25170	**Recommended Physician Work RVU: 22.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24363	090	22.47	**RUC Time**

CPT Descriptor Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 18.5 %

TIME ESTIMATES (Median)	**CPT Code: 25170**	**Key Reference CPT Code: 24363**	**Source of Time RUC Time**
Median Pre-Service Time	60.00	83.00	
Median Intra-Service Time	180.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**470.00**	**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	4.00	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.83
Urgency of medical decision making	4.17	3.83

Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	4.17
Physical effort required	4.30	4.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.17	3.83
Outcome depends on the skill and judgment of physician	4.33	4.00
Estimated risk of malpractice suit with poor outcome	4.50	4.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.17	3.33
Intra-Service intensity/complexity	4.33	3.83
Post-Service intensity/complexity	3.50	3.33

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of

these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW of 22.00. Along with the recommended time and visit information, this results in an IWPUT of 0.073. This RVW is less than the reference code 24363, which is also a demanding operation with less intra-operative time, but similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 25170

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 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. national, non-medicare, frequency not available

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? 30
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 26 Percentage 86.66 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26250 Tracking Number P55 Specialty Society Recommended RVU: **15.00**

Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Radical resection of tumor, metacarpal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with a chondrosarcoma of the first metacarpal of the thumb with a small soft tissue mass. A radical resection of the first metacarpal is performed with preservation of the thumb.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 36% , Kept overnight (less than 24 hours) 32% , Admitted (more than 24 hours) 32%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 78%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the dorsal aspect of the first metacarpal. The neurovascular structures are carefully retracted. The extensor mechanism is retracted. Extraperiosteal dissection is carried out around the metacarpal. The metacarpalphalangeal joint is identified and the capsule is incised. The flexor tendon sheath is opened and the flexor pollicis longus is retracted. The first metacarpal is carefully dissected away from the flexor pollicis longus and thenar muscles. The digital nerves and arteries are protected. The carpometacarpal joint is identified and its capsule incised. The metacarpal, the attached soft tissue tumor extension and the involved muscle are removed. The urniquet is released and meticulous hemostasis achieved. The wound is irrigated. A drain is placed in the wound. The ound is closed in layers.

Description of Post-Service Work: Apply soft dressings. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor

nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status... Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical recor and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, ; make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management reconstruction. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD		
Specialty(s):	MSTS; AAOS; ASSH		
CPT Code:	26250		
Sample Size:	75	**Resp N:** 27	**Response:** 36.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	1.00	**1.00**	2.00	15.00
Survey RVW:	7.00	14.00	**15.00**	22.00	40.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**120.00**	120.00	270.00

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	26250	**Recommended Physician Work RVU: 15.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**23.00**	**33.00**	**-10.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**5.00**	**10.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**25.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25447	090	10.95	**RUC Time**

CPT Descriptor Arthroplasty, interposition, intercarpal or carpometacarpal joints

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 22.2 %

TIME ESTIMATES (Median)	CPT Code: 26250	Key Reference CPT Code: 25447	Source of Time RUC Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	120.00	100.00	
Median Immediate Post-service Time	25.00	20.00	
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	102.0	94.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**353.00**	**278.00**	
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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	2.75
Urgency of medical decision making	4.00	3.15

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	3.25	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.50
Outcome depends on the skill and judgment of physician	3.25	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.25
Intra-Service intensity/complexity	3.25	3.00
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.*

ompelling Evidence

he MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of

these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advance have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 2B with the following modifications:

- Evaluation: Subtract 10 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: Add 10 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome – the hand typically swells extensively after this procedure. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey median RVW of 15.00. Along with the recommended time and visit information, this results in an IWPUT of 0.065. This RVW less than the reference code 25447, accounting for less intra-op and total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 26250

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 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. national, non-medicare, frequency not available

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? 23
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 16 Percentage 69.56 %

Specialty hand surgery Frequency 5 Percentage 21.73 %

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:26260 Tracking Number P56 Specialty Society Recommended RVU: **11.00**

Global Period: 090 RUC Recommended RVU: **11.00**

CPT Descriptor: Radical resection of tumor, proximal or middle phalanx of finger

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old woman presents with a chondrosarcoma of the proximal phalanx of the thumb in her dominant hand. A radical resection of the tumor is performed with preservation of the thumb.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 62% , Kept overnight (less than 24 hours) 23% , Admitted (more than 24 hours) 15%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 83%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the dorsal aspect of the proximal phalanx. The neurovascular structures are carefully retracted. The extensor mechanism is retracted. Extraperiosteal dissection is carried out around the phalanx. The interphalangeal joint is identified and the capsule is incised. The flexor tendon sheath is opened and the flexor pollicis longus is retracted. The proximal phalanx is carefully dissected away from the flexor pollicis longus. The digital nerves and arteries are protected. The metacarpalphalangeal joint is identified and its capsule incised. The phalanx is excised. The tourniquet is released and meticulous hemostasis achieved. The wound is irrigated. A drain is placed in the wound. The wound is closed.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the

operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD				
Specialty(s):	MSTS; AAOS; ASSH				
CPT Code:	26260				
Sample Size:	75	**Resp N:**	27	**Response:** 36.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**1.00**	3.00	15.00
Survey RVW:	8.00	11.00	**12.00**	20.00	40.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	79.00	**90.00**	120.00	200.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	26260	**Recommended Physician Work RVU: 11.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**23.00**	**33.00**	**-10.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**5.00**	**10.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
25447	090	10.95	**RUC Time**

CPT Descriptor Arthroplasty, interposition, intercarpal or carpometacarpal joints

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 14.8 %

TIME ESTIMATES (Median)	**CPT Code: 26260**	**Key Reference CPT Code: 25447**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	45.00	
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	79.0	94.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**256.00**	**278.00**	
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	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.00
Urgency of medical decision making	3.75	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.75
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.25
Outcome depends on the skill and judgment of physician	4.00	3.50
Estimated risk of malpractice suit with poor outcome	3.25	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	3.00
Post-Service intensity/complexity	4.00	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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends the survey 25th percentile RVW of 11.00. Along with the recommended time and visit information, this results in an IWPUT of 0.059. This RVW is similar to the reference code 25447 which has very similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 26260

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 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. national, non-medicare, frequency not available

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? 28
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 15 Percentage 53.57 %

Specialty hand surgery Frequency 8 Percentage 28.57 %

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:26262 Tracking Number P57 Specialty Society Recommended RVU: **8.13**

Global Period: 090 RUC Recommended RVU: **8.13**

CPT Descriptor: Radical resection of tumor, distal phalanx of finger

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old woman presents with chondrosarcoma of the distal phalanx of the thumb. A radical resection of the tumor is performed with preservation of the thumb.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 81% , Kept overnight (less than 24 hours) 15% , Admitted (more than 24 hours) 4%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Assist with patient positioning supine, with hand positioned on hand table and anesthesia staff and lines clear of operative site. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet on arm, prep the arm, scrub and gown. Drape the arm. Elevate the arm and inflate the pneumatic tourniquet. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the radial aspect of the distal phalanx. The neurovascular structures are carefully retracted. The extensor mechanism is retracted. Extraperiosteal dissection is carried out around the phalanx. The interphalangeal joint is identified and the capsule is incised. The flexor tendon sheath is opened and the flexor pollicis longus is retracted. The distal phalanx is carefully dissected away from the flexor pollicis longus, extensor policis longus and nail organ. The digital nerves and arteries are protected.. The phalanx is excised. The tourniquet is released and meticulous hemostasis achieved. The wound is irrigated. A drain is placed in the wound. The wound is 'osed.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Take specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the

operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications ; write order for pain medication. Provide necessary care coordination, telephonic or electronic communicat. assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD; Daniel Nagle, MD		
pecialty(s):	MSTS; AAOS; ASSH		
CPT Code:	26262		
Sample Size:	75	**Resp N:** 27	**Response:** 36.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**1.00**	3.00	15.00
Survey RVW:	5.90	8.00	**9.00**	11.00	27.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	53.00	**60.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	26262	**Recommended Physician Work RVU: 8.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**14.00**	**19.00**	**-5.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**5.00**	**5.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
ischarge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
ffice time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
24685	090	8.21	RUC Time

CPT Descriptor Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 25.9 %

TIME ESTIMATES (Median)	CPT Code: 26262	Key Reference CPT Code: 24685	Source of Time RUC Time
Median Pre-Service Time	34.00	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	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	79.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**212.00**	**252.00**	
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	3.29	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	2.71
Urgency of medical decision making	3.29	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	3.29
Physical effort required	3.14	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	3.14
Outcome depends on the skill and judgment of physician	3.71	3.29
Estimated risk of malpractice suit with poor outcome	3.43	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.29	3.00
Intra-Service intensity/complexity	3.29	3.43
Post-Service intensity/complexity	3.43	3.14

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all

of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: Subtract 5 minutes – move to scrub/dress wait category for moderate sedation performed by anesthesiologist.
- Positioning: Add 9 minutes. After induction of anesthesia in supine position, a hand table will be attached to the OR table. The hand is positioned on the arm table, anesthesia staff and lines will be adjusted for a clear operative site, and a tourniquet is applied.
- Scrub/Dress/Wait: Add 5 minutes – moved from evaluation category for moderate sedation performed by anesthesiologist.

Recommendation: The consensus committee recommends a RVW of 8.13. This is very similar to the survey 25th percentile RVW of 8.00 but allows 26262 to be valued the same as the recommended RVW for CPT code 28175 th maintaining rank order between 26262 and 28175. These two codes have virtually the exact same times and therefore, the committee believes their RVW and IWPUTs should be identical as well. The IWPUT is .061. In addition, this RVW is similar to the reference code 24685 which has very similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 26262

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 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. national, non-medicare, frequency not available

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? 32
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 14 Percentage 43.75 %

Specialty hand surgery Frequency 2 Percentage 6.25 %

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:27075 Tracking Number P64 Specialty Society Recommended RVU: **32.50**

Global Period: 090 RUC Recommended RVU: **32.50**

CPT Descriptor: Radical resection of tumor; wing of ilium, one public or ischial ramus or symphysis pubis

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male presents with a chondrosarcoma of the left superior pubic ramus involving the symphysis but sparing the acetabulum and an associated soft tissue mass into the obturator foramen. At operation, a radical resection of the tumor is performed with the resection of the soft tissue mass and preservation of the limb.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotics. Verify that all required instruments and supplies are available. Patient is placed in supine position. 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: A skin incision is made from the pubic symphysis over the inguinal ligament and over the superior bony rim of the pelvis going back posteriorly to the sacro-iliac joint. A second incision is then made over the lateral aspect of the proximal femur extending proximally to the mid lateral aspect of the first incision creating a large laterally based "T". This is carried down sharply through the skin and subcutaneous tissues and hemostasis is obtained. The anterior portion of the incision is then taken down through the inguinal ligament from the pubic symphysis to the anterosuperior iliac spine. The femoral artery and vein are exposed and carefully dissected. Vess loops are carefully placed around the femoral artery and vein in the pelvis so that proximal control can be maintained. The abdominal wall muscles are then dissected extraperiosteally from their insertion on the wing of the ileum. These muscles are retracted proximally. The lateral femoral cutaneous nerve is identified and protected. Dissection is then carried down over the iliacus muscle, which will be left with the resection specimen to form the medial wide margin. In the lower portion of the pelvis, the ureter is palpated and this is facilitated by the previously placed ureteral stent. The

ureter is carefully swept posteriorly and the peritoneum in retracted away from the mass. Dissection is then carried through the iliacus muscle but the psoas muscle is left intact. The femoral nerve is exposed within the anterior aspect of the psoas muscle and protected. Dissection is then carried posteriorly over the posterior aspect of the iliac wing back to the sacro-iliac joint again staying extraperiosteal to keep away form the tumor. The tensor fascia lata, sartorius and rectus femoris muscles originating from the anterior aspect of the pelvis are dissected. A lateral incision is made through the fascia lata and anterior and posterior flaps are fashioned. The gluteus maximus muscle is split in line with its fibers and the gluteus maximus is then separated from the underlying gluteus medius and minimus and is then retracted anteriorly and posteriorly. The gluteus medius is the separated from the underlying gluteus minimus, which is maintained with the specimen to serve as the lateral wide margin. This dissection is carried back to the sciatic notch and the gluteal vessels and nerves to the medius and maximus are preserved while the branches to the minimus are sacrificed. The sciatic notch is then exposed from within the pelvis and from without. A large Penrose drain is then drawn through the sciatic notch to protect the underlying vessels and nerves. The sciatic nerve is then dissected inside and outside the pelvis so that it is visualized throughout this region. The posterior aspect of the ileum is then exposed followed by exposure of the sacral ala by dissection of the paraspinous muscles to expose the posterior aspect of the sacral ala. Final exposure of the planned areas for the bone cuts above the acetabulum and along the sacrum are performed. A Steinman pin is then place through the supra-acetabular bone perpendicular to the long axis of the body with a second pin through the ala to outline the bone cuts and to make sure that the cuts will go through normal uninvolved bone to guarantee wide bone margins. With the portable x-ray obtained and showing the pins in good position, an oscillating saw is then used to make the bone cuts which are completed with a curved periosteal elevator and a mallet so as not to damage the underlying nerves and vessels. Once these cuts are completed, the ileum can be mobilized by careful incision of the remaining soft tissue attachments. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. Careful hemostasis is then obtained. And the wound is copiously irrigated. Two suction drains are then left deep in the wound and brought out proximally. The gluteus medius and maximus are repaired to the abdominal wall muscles with nonabsorbable suture. The remaining soft tissue is then repaired in layers with interrupted sutures and the skin with skin staples.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD;				
Specialty(s):	MSTS; AAOS				
CPT Code:	27075				
Sample Size:	60	**Resp N:**	35	**Response:** 58.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**2.00**	4.00	10.00
Survey RVW:	20.00	27.25	**32.50**	37.75	50.00
Pre-Service Evaluation Time:			**88.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	180.00	**240.00**	260.00	720.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(3b,, 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27075	**Recommended Physician Work RVU: 32.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**160.00**	99231x **2.00** 99232x **3.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	CPT Code: 27075	Key Reference CPT Code: 27134	Source of Time RUC Time
Median Pre-Service Time	63.00	90.00	
Median Intra-Service Time	240.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	160.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**633.00**	**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	5.00	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.14
Urgency of medical decision making	5.00	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.29
Physical effort required	5.00	4.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.29
Estimated risk of malpractice suit with poor outcome	4.57	3.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	5.00	3.57
Intra-Service intensity/complexity	4.86	4.14
Post-Service intensity/complexity	4.86	4.14

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.*

Compelling Evidence

1. Evidence that technology has changed physician work (i.e., diffusion of technology).

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are

only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer. Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

2. Evidence that incorrect assumptions were made in the previous valuation of the service.
Of the 20 malignant bone tumor codes, only one code was surveyed during the Harvard study for all components (pre, intra, and post), and the survey consisted of only six general orthopaedic surgeons. The other 19 codes were only surveyed for intra-operative time/work, with pre and post-service work predicted by algorithm. The current Medicare frequency for these codes ranges from a low of four to a high of 417, with most of the codes performed less than 100 times annually. We believe it is fair to say that the six general orthopaedic surgeons surveyed during the Harvard study were not likely familiar and fit to rate these major procedures that are most often referred to musculoskeletal tumor specialists. Subsequent to the Harvard study, 27075 was submitted by MTS and AAOS for review during the second 5-year-review. During this review of physician work, the RUC reviewed all components of work. The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate physician work for these codes. During the current survey process, we find that the intra-operative time and length of stay has decreased slightly for 27075. For this reason, we are asking for this code to be reviewed, as we are recommending that the work RVUs for 27075 be decreased slightly so that a rank order anomaly is not created with the other bone tumor codes.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: no change
- Scrub/Dress/Wait: no change
-

Hospital Visits: With respect to the hospital visits for 27075, we are recommending 5 total hospital visits, 2 at a level 99231 and 3 at a level of 99232. Our survey respondents indicated one visit would be at a level of 99233. However, the consensus committee felt that 3-99232 was the more appropriate recommendation.

Recommendation: The consensus committee recommends the survey median RVW of 32.50. This is less than the current RVW. Along with the recommended time and visit information, this results in an IWPUT of 0.083. This RVW is slightly greater than the reference (and MPC) code 27134 which has less total time and a similar IWPUT.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27075

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 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. national, non-medicare, frequency not available

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? 82
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 55 Percentage 67.07 %

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)

CPT Code: 27075

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.

ndicate 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:27076 Tracking Number P65 Specialty Society Recommended RVU: **40.00**

Global Period: 090 RUC Recommended RVU: **40.00**

CPT Descriptor: Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male presents with a malignant fibrous histiocytoma of the acetabulum and an associated soft tissue mass. At operation, a radical resection of the tumor with adjacent soft tissue is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. 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: The incision starts at the medial aspect of the inguinal ligament and goes laterally over the proximal border of the pelvis and posteriorly to the SI joint with a second arm of the incision coursing distally from the mid lateral portion of the previous incision to a points 10 cm below the greater trochanter, ellipsing the biopsy tract in a wide en bloc fashion. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the groin and pelvis to the fascia of the gluteus maximus and the inguinal ligament. The inguinal ligament is opened and the femo neurovascular bundle is exposed taking great care to protect these structures. The sartorius and tensor fascia la muscles are incised extra periosteally and the anterior aspect of the pelvis is exposed keeping normal tissues between the tumor and the plain of dissection. The gluteus maximus muscle is the split along the lateral potion of the proximal thigh and this dissection is carried proximally so that this can be separated from the underlying gluteus medius. The gluteus maximus is then retracted posteriorly as its proximal origin is removed from the ileum. The gluteus medius and

minimus are kept with the specimen to effect a wide margin laterally. The iliacus and psoas muscles are divided in the pelvis after first dissecting the femoral vessels in this region to effect a wide margin on the interior of the pelvis. Posteriorly, the sciatic nerve must be found and protected from undue tension or retractors. The abductor muscles are then divined from the greater trochanter and the femur is internally rotated. The short external rotator muscles are then ivided and perforating vessels are ligated. The hip capsule is then dissected circumferentially and then incised keeping away from the pelvic origin which is in close proximity to tumor. The osteotomies of the posterior ileum, pubis and ischium are carefully planned and scribed on the boney pelvis. The ligamentum teres is then incised. The osteotomies are then performed with an oscillating saw and completed with a cob and a mallet. Soft tissue attachments still connect the specimen to the underlying structures and these are carefully divided. The hip is then dislocated and the specimen is lifted gently out of the wound as the remaining soft tissue attachments are divided. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. Hemostasis of the wound is secured. The remaining bone edges are rasped to a fine finish. Irrigation is performed. The gluteus maximus is repaired and re-approximated to itself. The fascia is closed over a drain. Subcutaneous tissues and skin are closed in the usual fashion.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing eurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and evise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD;		
Specialty(s):	MSTS; AAOS		
CPT Code:	27076		
Sample Size:	60	**Resp N:** 35	**Response:** 58.3 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	4.00	10.00
Survey RVW:	32.00	40.00	**40.00**	45.00	90.00
Pre-Service Evaluation Time:			**95.00**		
Pre-Service Positioning Time:			**30.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	180.00	290.00	**360.00**	480.00	720.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**235.00**	99231x **3.00** 99232x **3.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38,, 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27076	**Recommended Physician Work RVU: 40.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**360.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**220.00**	99231x **3.00** 99232x **4.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20956	090	40.90	**RUC Time**

CPT Descriptor Bone graft with microvascular anastomosis; iliac crest

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
15756	090	36.74	**RUC Time**	540

CPT Descriptor 1 Free muscle or myocutaneous flap with microvascular anastomosis

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19364	090	36.74	**RUC Time**	191

CPT Descriptor 2 Breast reconstruction with free flap

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 60.0 %

TIME ESTIMATES (Median)	**CPT Code: 27076**	**Key Reference CPT Code: 20956**	**Source of Time RUC Time**
Median Pre-Service Time	80.00	90.00	
Median Intra-Service Time	360.00	400.00	
Median Immediate Post-service Time	40.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	220.0	180.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	126.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**840.00**	**894.00**	
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	5.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.17
Urgency of medical decision making	4.78	3.72

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.78
Physical effort required	5.00	4.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.39
Outcome depends on the skill and judgment of physician	5.00	4.78
Estimated risk of malpractice suit with poor outcome	4.44	4.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	5.00	4.33
Intra-Service intensity/complexity	5.00	4.72
Post-Service intensity/complexity	5.00	4.50

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.*

Compelling Evidence

1. Evidence that technology has changed physician work (i.e., diffusion of technology).

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor

revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer. Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

2. Evidence that incorrect assumptions were made in the previous valuation of the service.
Of the 20 malignant bone tumor codes, only one code was surveyed during the Harvard study for all components (pre, intra, and post), and the survey consisted of only six general orthopaedic surgeons. The other 19 codes were only surveyed for intra-operative time/work, with pre and post-service work predicted by algorithm. The current Medicare frequency for these codes ranges from a low of four to a high of 417, with most of the codes performed less than 100 times annually. We believe it is fair to say that the six general orthopaedic surgeons surveyed during the Harvard study were not likely familiar and fit to rate these major procedures that are most often referred to musculoskeletal tumor specialists. Subsequent to the Harvard study, 27076 was submitted by MTS and AAOS for review during the first 5-year-review. The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate the intra-operative work. Total work, intra-operative intensity, and levels of hospital and office visits were not considered – only difference in intra-operative time. New work values were calculated by adding an additional RVU increment to account for the different in intra-operative time between the Harvard study and the RUC survey. The calculated RVW resulted in an IWPUT of 0.022. If the correct level of hospital visits were considered and corrected, a negative IWPUT results. The current survey provides time and visit data from surgeons familiar with these procedures. Intra-operative time for both codes is significantly greater than recorded in 1995. For this reason, we are asking for these codes to be reviewed at this time for all survey components (pre, intra, post).

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning
- Scrub/Dress/Wait: no change

Hospital Visits: With respect to the hospital visits for 27076, we are recommending 7 total hospital visits, 3 at a level 99231 and 4 at a level of 99232. Our survey respondents indicated one visit would be at a level of 99233. However, the consensus committee felt that 4-99232 was the more appropriate recommendation.

Recommendation: The consensus committee recommends the survey median RVW of 40.00. Along with the recommended time and visit information, this results in an IWPUT of 0.069. This RVW is less than the reference code 20956 which has similar total time and IWPUT, but a different pattern of time and visit details.

SERVICES REPORTED WITH MULTIPLE 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 th CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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) 27076

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 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. national, non-medicare, frequency not available

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? 82
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 55 Percentage 67.07 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27077 Tracking Number P66 Specialty Society Recommended RVU: **45.00**

Global Period: 090 RUC Recommended RVU: **45.00**

CPT Descriptor: Radical resection of tumor; innominate bone, total

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old women presents with an osteosarcoma of the acetabulum with extension to the ilium, ischium and the superior pubic ramus to the symphysis. At operation a radical resection of the entire hemipelvis is performed with preservation of the limb.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. 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: A skin incision is then made from the pubic symphysis over the inguinal ligament and over the superior bony rim of the pelvis going back posteriorly to the sacro-iliac joint. A second incision is then made over the lateral aspect of the proximal femur extending proximally to the mid lateral aspect of the first incision creating a large laterally based "T". This is carried down sharply through the skin and subcutaneous tissues and hemostasis is obtained. The anterior portion of the incision is then taken down through the inguinal ligament from the pubic symphysis to the anterosuperior iliac spine. The femoral artery and vein are exposed and carefully dissected. Vessel loops are carefully placed around the femoral artery and vein in the pelvis so that proximal control can be maintained. The abdominal wall muscles are then dissected extraperiosteally from their insertion on the wing of the ileum. These muscles are retracted proximally. In the course of doing this, the lateral femoral cutaneous nerve is identified and protected. Dissection is then carried down over the iliacus muscle, which will be left with the resection

specimen to form the medial wide margin. In the lower portion of the pelvis, the ureter is palpated and this is facilitated by the previously placed ureteral stent. The ureter is carefully swept posteriorly and the peritoneum in retracted away from the mass. Dissection is then carried through the iliacus and psoas muscles. The femoral nerve is exposed within the anterior aspect of the psoas muscle and protected. Dissection is then carried posteriorly over the posterior aspect of the iliac wing back to the sacro-iliac joint. The muscles originating from the anterior aspect of the pelvis are then dissected extraperiosteally and these include the tensor fascia lata, sartorius and rectus femoris muscles. The lateral incision is then incised through the fascia lata and anterior and posterior flaps are fashioned. The gluteus maximus muscle is split in line with its fibers and the gluteus maximus is then separated from the underlying gluteus medius and minimus and is then retracted anteriorly and posteriorly. The gluteus medius is the separated from the underlying gluteus minimus, which is maintained with the specimen to serve as the lateral wide margin. This dissection is carried back to the sciatic notch and the gluteal vessels and nerves to the medius and maximus are preserved while the branches to the minimus are sacrificed. The sciatic notch is then exposed from within the pelvis and from without. A large Penrose drain is then drawn through the sciatic notch to protect the underlying vessels and nerves. The sciatic nerve is then dissected inside and outside the pelvis so that it is visualized throughout this region. The posterior aspect of the ileum is then exposed followed by exposure of the sacral ala by dissection of the paraspinous muscles to expose the posterior aspect of the sacral ala. Dissection is then carried around the hip capsule circumferentially and the anterior and posterior circumflex vessels are identified, ligated and incised. The ligamentum teres is incised and the hip joint is dislocated. The insertion of the iliopsoas muscle on the lesser is identified and incised. Dissection is the carried down the outside of the ischium detaching the origin of the hamstring muscles and being careful to remain in the extraperiosteal plane to keep away from the underlying tumor. Dissection is then carried over the pubis and the femoral artery and vein are skeletonized in this area and carefully retracted anteriorly. The inner wall of the pubis is then dissected and the pubis is separated from the bladder in the space of Retzius. The obturator vessels and nerves are visualized in the pelvis and ligated and incised. The origin of the adductor muscles is then dissected extraperiosteally and the obturator vessels and nerves are identified, ligated and incised in the adductor muscles outside the pelvis. A large Penrose drain is place around the pubic symphysis to protect the bladder during subsequent bone cuts. Final exposure of the planned areas for the bone cuts through the pubic symphysis and along the sacrum are performed. An oscillating saw is then used to make the bone cuts, which are then completed with a curved periosteal elevator and a mallet so as not to damage the underlying nerves and vessels. Once these cuts are completed, the innominate bone can be mobilized by careful incision of the remaining soft tissue attachments. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. Careful hemostasis is then obtained and the wound is copiously irrigated. Two suction drains are then left deep in the wound and brought out proximally. The gluteus medius and maximus are repaired to the abdominal wall muscles with nonabsorbable suture. The remaining soft tissue is then repaired in layers with interrupted sutures and the skin with skin staples.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including time restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound.

Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and furt' chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD;				
Specialty(s):	MSTS; AAOS				
CPT Code:	27077				
Sample Size:	60	**Resp N:**	35	**Response:** 58.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	10.00
Survey RVW:	35.00	40.00	**45.00**	49.00	60.00
Pre-Service Evaluation Time:			**90.00**		
Pre-Service Positioning Time:			**30.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	240.00	360.00	**400.00**	480.00	720.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**255.00**	99231x **4.00** 99232x **3.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27077	**Recommended Physician Work RVU: 45.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**400.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**240.00**	99231x **4.00** 99232x **4.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20956	090	40.90	**RUC Time**

CPT Descriptor Bone graft with microvascular anastomosis; iliac crest

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
15756	090	36.74	**RUC Time**	540

CPT Descriptor 1 Free muscle or myocutaneous flap with microvascular anastomosis

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20973	090	46.95	**RUC Time**	0

CPT Descriptor 2 Free osteocutaneous flap with microvascular anastomosis; great toe with web space

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 60.0 %

TIME ESTIMATES (Median)

	CPT Code: 27077	**Key Reference CPT Code: 20956**	**Source of Time RUC Time**
Median Pre-Service Time	80.00	90.00	
Median Intra-Service Time	400.00	400.00	
Median Immediate Post-service Time	45.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	240.0	180.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	126.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**905.00**	**894.00**	
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	5.00	4.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.21
Urgency of medical decision making	4.83	3.92

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.79
Physical effort required	5.00	4.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.63
Outcome depends on the skill and judgment of physician	5.00	4.79
Estimated risk of malpractice suit with poor outcome	4.58	4.42

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	5.00	4.38
Intra-Service intensity/complexity	5.00	4.71
Post-Service intensity/complexity	5.00	4.54

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.*

'ompelling Evidence

. Evidence that technology has changed physician work (i.e., diffusion of technology).

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer. Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

2. Evidence that incorrect assumptions were made in the previous valuation of the service.
Of the 20 malignant bone tumor codes, only one code was surveyed during the Harvard study for all components (pre, intra, and post), and the survey consisted of only six general orthopaedic surgeons. The other 19 codes were only surveyed for intra-operative time/work, with pre and post-service work predicted by algorithm. The current Medicare frequency for these codes ranges from a low of four to a high of 417, with most of the codes performed less than 100 times annually. We believe it is fair to say that the six general orthopaedic surgeons surveyed during the Harvard study were not likely familiar and fit to rate these major procedures that are most often referred to musculoskeletal tumor specialists. Subsequent to the Harvard study, 27077 was submitted by MTS and AAOS for review during the second 5-year-review. During this review of physician work, the RUC reviewed all components of work. The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate physician work for these codes. During the current survey process, we find that the intra-operative time and length of stay has increased significantly for 27077. For this reason, we are asking for this code to be reviewed.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning.
- Scrub/Dress/Wait: no change

Hospital Visits: With respect to the hospital visits for 27077, we are recommending 8 total hospital visits, 4 at a level 99231 and 4 at a level of 99232. Our survey respondents indicated one visit would be at a level of 99233. However, the consensus committee felt that 4-99232 was the more appropriate recommendation.

Recommendation: The consensus committee recommends the survey median RVW of 45.00. Along with the recommended time and visit information, this results in an IWPUT of 0.072. This RVW is greater than the reference code 20956 which has less total time and a different pattern of time and visit details.

SERVICES REPORTED WITH MULTIPLE 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) 27077

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 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. national, non-medicare, frequency not available

pecialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 6 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)

oes 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:27078 Tracking Number P67 Specialty Society Recommended RVU: **32.00**

Global Period: 090 RUC Recommended RVU: **32.00**

CPT Descriptor: Radical resection of tumor; ischial tuberosity and greater trochanter of femur

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female presents with a malignant fibrous histiocytoma of the ischial tuberosity. At operation, a radical resection of the tumor with adjacent soft tissues is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
'ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made, ellipsing the biopsy tract in a wide en bloc fashion. The incision is made from the upper buttocks to the upper thigh, incorporating the biopsy tract. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the buttocks, to the fascia of the gluteus maximus. The fascia is opened and e fibers of the muscles are split in order to gain exposure down to the ischium without having to transect the muscle ellies. Extreme care is required in order to prevent injury to the sciatic nerve. The sciatic nerve must be found and protected from undue tension or retractors. A tape is placed around the nerve and it is gently reflected to one side. The hamstring origin is then approached and transected from the underlying bone. A portion of the muscle origin however must be maintained in continuity with the ischium in order to secure a clear margin around the tumor. An extra-periosteal dissection is then carried proximally along the ischium, towards the pubic rami, both superior and inferior to

the edges of the tumor. Once the affected bone is completely dissected free from surrounding soft tissues, a subperiosteal dissection is performed circumferentially around either end of the bone beyond the area of tumor involvement. A saw is then used to create the osteotomy at least 2 centimeters proximal to the tumor laden ischium, and then another osteotomy is created distal to the tumor. Large amounts of remaining soft tissue are then dissected leav normal tissue with the specimen. By completing the osteotomies, the specimen can be mobilized and ultimately fi from the surrounding tissues. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The remaining bone edges are rasped to a fine finish. Irrigation is performed. The gluteus maximus is repaired and re-approximated to itself. The fascia is closed over a drain. Subcutaneous tissues and skin are closed in the usual fashion.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary manageme Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD;				
Specialty(s):	MSTS; AAOS				
CPT Code:	27078				
Sample Size:	60	**Resp N:**	35	**Response:** 58.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**3.00**	10.00	20.00
Survey RVW:	20.00	29.00	**32.00**	40.00	50.00
Pre-Service Evaluation Time:			**90.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	150.00	180.00	**240.00**	300.00	720.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27078	**Recommended Physician Work RVU: 32.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**160.00**	99231x **2.00** 99232x **3.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 31.4 %

TIME ESTIMATES (Median)	**CPT Code: 27078**	**Key Reference CPT Code:** 27134	**Source of Time** **RUC Time**
Median Pre-Service Time	80.00	90.00	
Median Intra-Service Time	240.00	240.00	
Median Immediate Post-service Time	45.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	160.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**665.00**	**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	5.00	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.73
Urgency of medical decision making	4.82	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.45
Physical effort required	5.00	4.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.36
Outcome depends on the skill and judgment of physician	5.00	4.55
Estimated risk of malpractice suit with poor outcome	4.45	3.82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.91	3.82
Intra-Service intensity/complexity	4.91	4.27
Post-Service intensity/complexity	4.64	3.64

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: Add 20 minutes for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with reconstructive surgeon.
- Positioning: Add 17 minutes for prone positioning.
- Scrub/Dress/Wait: no change

Hospital Visits: With respect to the hospital visits for 27078, we are recommending 5 total hospital visits, 2 at a level 99231 and 3 at a level of 99232. Our survey respondents indicated one visit would be at a level of 99233. However, the consensus committee felt that 3-99232 was the more appropriate recommendation.

Recommendation: The consensus committee recommends the survey median RVW of 32.00. Along with the recommended time and visit information, this results in an IWPUT of 0.078. This RVW and IWPUT is similar the reference code 27134, which is also a demanding operation, but has less total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 27078

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 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. national, non-medicare, frequency not available

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? 55
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 34 Percentage 61.81 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27365 Tracking Number P74 Specialty Society Recommended RVU: **32.00**

Global Period: 090 RUC Recommended RVU: **32.00**

CPT Descriptor: Radical resection of tumor, femur or knee

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old female presents with an osteosarcoma of the distal femur. At operation, a radical resection of the tumor with adjacent soft tissues is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. Patient is placed in supine position. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made, ellipsing the biopsy tract in a wide en bloc fashion. The incision is made from the upper thigh, incorporating the biopsy tract, extending the incision to approximately 12 cm below the knee. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the thigh, extending down to the patella and along its side, then to the tibial tubercle. The tumor originated in the distal end of the femur but has an associated soft tissue mass that involves the quadriceps and hamstrings. The dissection therefore proceeds through t' quadriceps, once again, maintaining a cuff of quadriceps muscle on the tumor to maintain a wide margin. The rect. femoris muscle is dissected from the underlying vastus intermedius followed by dissection through a portion of the vastus lateralis and the vastus medialis. The vastus intermedius is maintained around the soft tissue component of the tumor. At the level of the knee, an arthrotomy is made, incising through the joint capsule at the level of the tibia to ensure a cuff of tissue being maintained around the tumor and distal femur. Dissection is carried further towards the

patellar tendon, along its length down to its insertion into the tibia. This allows for the mobilization of the patella. The patella is everted thus exposing the joint. The anterior cruciate ligament is identified and divided. The posterior cruciate ligament is divided followed by subluxation of the knee forwards in order to bring the menisci into view. Both the lateral collateral ligament is identified and divided as well as the medial collateral ligament followed by total meniscectomy of both the medial and lateral menisci. The remaining capsular structures are then transected being very careful of the neurovascular structures (artery, vein, and both tibial and peroneal nerves) which lie intimately in contact with the back of the knee joint. The femur is elevated forwards to allow for exposure of the back of the thigh. The neurovascular structures are identified and carefully dissected one by one off of the overlying femur. The sheath must be opened in order to be able to dissect the vein, nerve and artery in a sub-adventitial fashion from the tumor. The hamstring muscles are carefully divided from the now overlying soft tissue component of the tumor and femur. Each hamstring muscle is individually divided by dissection from the overlying mass. This allows for completion of the dissection of the artery then vein, then both peroneal and tibial components of the sciatic nerve from the remaining muscles and tumor. Care is taken to ligate each feeding vessel into the tumor and femur as it is approached an s the tumor does often have neovascularity. The dissection is carried proximally in this fashion until the level of the proposed osteotomy dictated by the pre-operative planning. At this point, 18 cm. above the knee, the dissection is carried circumferentially around the entire femur. The periosteum is elevated from the femur 2 cm proximal to the proposed cut in the bone to allow for later overlap of the periosteum over the prosthesis. The bone is marked with a saw blade to demonstrate orientation once the prosthesis is inserted. The bone is then cut with a saw and the remaining soft tissues are dissected free from the specimen. The specimen consists of the skin of the biopsy tract, the underlying subcutaneous fat, fascia, muscle, tumor, bone, ligaments, tendons, and capsular structures, all in one piece. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. The wound bed is inspected, bleeding vessels are taken care of and the neurovascular structures are re-evaluated to ensure they are intact. During the remainder of the procedure, these structures must be protected from stretch, twisting, retraction, etc. as there is now no bone to provide structure of this limb. The fascial layers are closed in a watertight fashion over a large bore drain, followed by closure of the subcutaneous tissues and skin.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD;		
Specialty(s):	MSTS; AAOS		
CPT Code:	27365		
Sample Size:	60	**Resp N:** 35	**Response:** 58.3 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**8.00**	10.00	40.00
Survey RVW:	25.00	30.00	**32.00**	36.00	45.00
Pre-Service Evaluation Time:			**85.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	180.00	**240.00**	300.00	480.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30,, 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27365	**Recommended Physician Work RVU: 32.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**240.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**160.00**	99231x **2.00** 99232x **3.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
	090		RUC Time	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		RUC Time	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 31.4 %

TIME ESTIMATES (Median)	CPT Code: 27365	Key Reference CPT Code: 27134	Source of Time RUC Time
Median Pre-Service Time	63.00	90.00	
Median Intra-Service Time	240.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	160.0	140.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**633.00**	**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	4.78	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.89	3.44
Urgency of medical decision making	4.72	2.89

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.28
Physical effort required	4.72	4.39

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.72	4.06
Outcome depends on the skill and judgment of physician	4.83	4.39
Estimated risk of malpractice suit with poor outcome	4.44	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.72	4.11
Intra-Service intensity/complexity	4.50	3.67
Post-Service intensity/complexity	4.17	4.00

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 as follows:

- Evaluation: no change
- Positioning: no change
- Scrub/Dress/Wait: no change

Hospital Visits: With respect to the hospital visits for 27365, we are recommending 75 total hospital visits, 2 at a level 99231 and 3 at a level of 99232. Our survey respondents indicated one visit would be at a level of 99233. However, the consensus committee felt that 3-99232 was the more appropriate recommendation.

Recommendation: The consensus committee recommends the survey median RVW of 32.00. Along with the recommended time and visit information, this results in an IWPUT of 0.081. This RVW is similar to the reference ode 27134 which has very similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27365

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 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. national, non-medicare, frequency not available

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? 417
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 400 Percentage 95.92 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27645 Tracking Number P81 Specialty Society Recommended RVU: **27.00**

Global Period: 090 RUC Recommended RVU: **27.00**

CPT Descriptor: Radical resection of tumor; tibia

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15-year-old female presents with a Ewing's sarcoma of the proximal tibia. At operation, a radical resection of the tumor with adjacent soft tissues is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 3% , Admitted (more than 24 hours) 97%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotics. Verify that all required instruments and supplies are available. Patient is placed in supine position. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made, ellipsing the biopsy tract in a wide en bloc fashion. The incision is made from the lower thigh, incorporating the biopsy tract, extending the incision to approximately 4 inches above the ankle. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the leg, extending down to the patella and along its side, then towards the tibial tubercle. The dissection is then carried further down the ; to nearly the ankle. The tumor originated in the proximal end of the tibia but has an associated soft tissue mass that volves the anterior and posterior musculature of the entire leg. The dissection therefore then proceeds through the tibialis anterior, and extensors of the foot and ankle, then laterally through the peroneal muscles, once again, maintaining a cuff of normal tissue on the tumor to maintain wide margins around the tumor. The tibialis anterior, extensors and peroneals are dissected from the underlying musculature overlying the bone itself. All neurovascular structures are meticulously dissected free from the overlying tumor. At the level of the knee, an arthrotomy is made, incising through

he joint capsule at the level of the femur to ensure a cuff of tissue being maintained around the tumor and proximal tibia. Dissection is carried further towards the patellar tendon, along its length up to its origin on the patella. This allows for the mobilization of the patella. The patella tendon is transected from the tibial tubercle. The patella is everted thus exposing the joint. The anterior cruciate ligament is identified and divided. The posterior cruciate ligament is divi followed by subluxation of the knee forwards in order to bring the menisci into view. Both the lateral collateral ligan is identified and divided as well as the medial collateral ligament followed by total meniscectomy of both the medial and lateral menisci. The remaining capsular structures are then transected being very careful of the neurovascular structures (artery, vein, and both tibial and peroneal nerves) which lie intimately in contact with the back of the knee joint. The tibia is elevated forwards to allow for exposure of the back of the leg. The gastrocnemius and soleus muscles are carefully divided from the now overlying soft tissue component of the tumor and tibia. Dissection of the artery then vein, then both peroneal and tibial components of the sciatic nerve from the remaining muscles and tumor is performed. Care is taken to ligate each feeding vessel into the tumor and femur as it is approached as the tumor does often have neovascularity. The dissection is carried distally in this fashion until the level of the proposed osteotomy dictated by the pre-operative planning. At this point, 16 cm. below the knee, the dissection is carried circumferentially around the entire tibia. The periosteum is elevated from the tibia one to two cm. distal from the proposed cut in the bone to allow for later overlap of the periosteum over the prosthesis. The bone is marked with a saw blade to demonstrate orientation for later reconstruction. The bone is then cut with a saw and the remaining soft tissues are dissected free from the specimen. The specimen consists of the skin of the biopsy tract, the underlying subcutaneous fat, fascia, muscle, tumor, bone, ligaments, tendons, and capsular structures, all in one piece, without any contamination of tumor from prior surgery. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. The wound bed is inspected, bleeding vessels are ligated and the neurovascular structures are re-evaluated to ensure they are intact. During the remainder of the procedure, these structures must be protected fr stretch, twisting, retraction, etc. as there is now no bone to provide structure of this limb. Muscles are mobilized order to provide coverage for the closure. The remaining gastrocnemius, tibials, peroneals, etc. are mobilized by dissecting them free from their fascial boundaries and brought together to provide a good wound bed. Muscles are sutured to each other followed by closure of fascia over a drain, then skin closure.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic la and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatm plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordinatio telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD;				
Specialty(s):	MSTS; AAOS				
CPT Code:	27645				
Sample Size:	100	**Resp N:**	30	**Response:** 30.0 %	
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:	17.61	25.00	**27.00**	35.00	60.00
Pre-Service Evaluation Time:			**83.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	180.00	**200.00**	240.00	420.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**120.00**	99231x **2.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27645	**Recommended Physician Work RVU: 27.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**200.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**120.00**	99231x **2.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27156	090	26.03	**RUC Time**

CPT Descriptor Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)

	CPT Code: 27645	**Key Reference CPT Code:** 27156	**Source of Time** **RUC Time**
Median Pre-Service Time	63.00	83.00	
Median Intra-Service Time	200.00	225.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	120.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	102.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**553.00**	**538.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

1ental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.80	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	3.70
Urgency of medical decision making	4.70	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	4.70	4.30
Physical effort required	4.70	4.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.70	4.30
Outcome depends on the skill and judgment of physician	4.90	4.60
Estimated risk of malpractice suit with poor outcome	4.60	4.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	5.00	4.20
Intra-Service intensity/complexity	4.90	4.50
Post-Service intensity/complexity	4.70	3.90

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.*

ompelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 as follows:

- Evaluation: no change
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW of 27.00. Along with the recommended time and visit information, this results in an IWPUT of 0.080. This RVW is similar to the reference code 27156 which has very similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27645

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 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. national, non-medicare, frequency not available

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? 59
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 53 Percentage 89.83 %

Specialty podiatryu Frequency 3 Percentage 5.08 %

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:27646 Tracking Number P82 Specialty Society Recommended RVU: **23.00**

Global Period: 090 RUC Recommended RVU: **23.00**

CPT Descriptor: Radical resection of tumor; fibula

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with a malignant fibrous histiocytoma of the fibula. At operation, a radical resection of the tumor with adjacent soft tissues is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 7% , Admitted (more than 24 hours) 93%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape leg. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made, ellipsing the biopsy tract in a wide en bloc fashion. The incision is made from the distal thigh, incorporating the biopsy tract, extending the incision to approximately 10 cm above the ankle. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the leg, extending down from the lateral distal thigh to the ankle. The tumor is associated with a large soft tissue mass that involves the anterior a posterior musculature of the leg. The dissection therefore proceeds through the peroneal longus and brevis muscles, a the extensor muscles of the foot and ankle, once again, maintaining a cuff of normal muscle on the tumor to affect a wide margin. The muscle bellies are dissected from the underlying musculature overlying the bone itself. All neurovascular structures are meticulously dissected free from the overlying tumor. At the level of the knee, an arthrotomy is made, through the capsule of the tibio-fibular joint in order to mobilize the fibula. Care is necessary, as

the anterior tibial vessels course directly in the path and must be dissected free and preserved. The lateral collateral ligament must be divided for resection of the fibula... The gastrocnemius and soleus muscles are carefully divided from the overlying soft tissue component of the tumor and tibia. Dissection of the popliteal artery, vein and tibial and peroneal nerves from the remaining muscles and tumor is performed. Care is taken to ligate each feeding vessel into the tumor. The dissection is carried distally in this fashion until the level of the proposed osteotomy dictated by the pre-operative planning. At this point, 18 cm. below the knee, the dissection is carried circumferentially around the entire fibula... The bone is then cut with a saw and the remaining soft tissues are dissected free from the specimen. The specimen consists of the skin of the biopsy tract, the underlying subcutaneous fat, fascia, muscle, tumor, bone, ligaments, tendons, and capsular structures, all in one piece. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. The wound bed is inspected, bleeding vessels are taken care of and the neurovascular structures are re-evaluated to ensure they are intact. During the remainder of the procedure, these structures must be protected from stretch, twisting, retraction, etc. as there is now no bone to provide structure of this limb and the nerve could inadvertently be stretched. The fascial layers are closed in a watertight fashion over a drain, followed by closure of the subcutaneous tissues and skin.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks and revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examine and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009		
Presenter(s):	John Heiner, MD; William Creevy, MD;		
Specialty(s):	MSTS; AAOS		
CPT Code:	27646		
Sample Size:	100	**Resp N:** 30	**Response:** 30.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	3.00	10.00
Survey RVW:	10.63	23.00	**23.00**	28.00	50.00
Pre-Service Evaluation Time:			**80.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	75.00	150.00	**180.00**	200.00	420.00

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	27646	**Recommended Physician Work RVU: 23.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**40.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**102.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)	CPT Code: 27646	Key Reference CPT Code: 27447	Source of Time RUC Time
Median Pre-Service Time	80.00	75.00	
Median Intra-Service Time	180.00	124.00	
Median Immediate Post-service Time	40.00	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	102.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**540.00**	**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	5.00	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	3.67
Urgency of medical decision making	4.83	3.08

Technical Skill/Physical Effort (Mean)

Technical skill required	4.92	4.25
Physical effort required	4.83	4.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.92	4.25
Outcome depends on the skill and judgment of physician	4.92	4.42
Estimated risk of malpractice suit with poor outcome	4.58	4.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	5.00	3.58
Intra-Service intensity/complexity	4.92	4.33
Post-Service intensity/complexity	4.75	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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes for lateral positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW of 23.00. Along with the recommended time and visit information, this results in an IWPUT of 0.067. This RVW is similar to the reference code 27447 which has very similar total work and similar post-operative time, although the IWPUT for 27646 is less than that of 27447 (.099). The intra-service times between 27447 and 27646 are quite distinct, however the survey intra-service time for 27646 is consistent with the intra-service times for other radical bone tumor codes that were surveyed.

SERVICES REPORTED WITH MULTIPLE 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) 27646

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 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. national, non-medicare, frequency not available

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? 31
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 22 Percentage 70.96 %

Specialty podiatry Frequency 4 Percentage 12.90 %

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:27647 Tracking Number P83 Specialty Society Recommended RVU: **20.10**

Global Period: 090 RUC Recommended RVU: **20.10**

CPT Descriptor: Radical resection of tumor; talus or calcaneus

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old female presents with a Ewing's sarcoma of the calcaneus. At operation, a radical resection of the calcaneus is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 10% , Admitted (more than 24 hours) 90%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 67%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient prone positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A longitudinal incision is made, ellipsing the biopsy tract in a wide en bloc fashion. The incision is made from the distal leg, incorporating the biopsy tract, extending the incision to the mid foot in a hockey stick configuration. The dissection is carried down through the subcutaneous fat maintaining a cuff of tissue surrounding the biopsy tract and tumor. The incision is carried down through the limiting fascia of the foot and ankle, tending down from the distal leg to the midfoot. The tumor is associated with a soft tissue mass that involves the edial and lateral compartments at the ankle. The dissection therefore proceeds and flaps are created to allow for later reconstruction. Due to the soft tissue component of the tumor, this requires intra-operative modification of flaps in order to ensure that the wound will be able to be closed and that the skin flaps will survive. A cuff of normal muscle is maintained on the tumor to insure a wide margin. The muscle bellies are dissected from the underlying musculature. All neurovascular structures are meticulously dissected free from the overlying tumor. At the level of the articular

surface, an arthrotomy is made, through the capsule of the ankle joint in order to mobilize the calcaneus. Care is necessary, as the dorsal vessels course directly in the path and must be dissected free and preserved. The collateral ligament must be divided for resection of the bone. Care is taken to ligate each feeding vessel into the tumor. The dissection is carried distally in this fashion until the level of t`he proposed resection dictated by the pre-opera' planning. At this point, typically, the dissection is carried circumferentially around the entire bone. The remaining tissues are dissected free from the specimen. The specimen consists of the skin of the biopsy tract, the underlying subcutaneous fat, fascia, muscle, tumor, bone, ligaments, tendons, and capsular structures, all in one piece, without any contamination from tumor from prior surgery. The specimen is then removed from the field and marked for anatomic orientation. This is documented on the pathology request form along with appropriate history and needed information. The surgeon then breaks scrub and carries the specimen to the pathology department while the anesthesiologist and other operative personnel remain with the patient. Prior to this, the surgeon assesses the stability of the operative field and discusses with the anesthesiologist the stability of the patient. In the pathology department, the surgeon then examines the resected specimen with the attending pathologist and orients the pathologist to the specimen anatomy. The specimen is then inked for margins and any areas that are questionable are inspected by frozen section. The surgeon then returns to the operative suite and scrubs in to the operation. The wound bed is inspected, bleeding vessels are taken care of and the neurovascular structures are re-evaluated to ensure they are intact. During the remainder of the procedure, these structures must be protected from stretch, twisting, retraction, etc. as there is now no bone to provide structure of this limb and the nerve could inadvertently be stretched. The remaining muscles are rotated to fill in the void left by the resection. All muscle flaps are sutured in place to ensure that the prosthesis is completely covered... The fascial layers are closed in a watertight fashion followed by closure of the subcutaneous tissues and skin.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff... Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room, including neurovascular status. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Exam patient, assessing neurovascular status and drain. Order and review imaging as necessary. Consider relevant data, options, and risks a revise treatment plan as necessary. On subsequent days, review medical records and interval data charted. Examin and talk with patient. Take down dressings, assess wound and patient status. When the patient is stable, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for continued anticoagulation and pain medication as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	John Heiner, MD; William Creevy, MD;Tye Ouzounian, MD; Frank Spinosa, DPM; Robb Mothershed, DPM; Timothy Tillo, DPM					
Specialty(s):	MSTS; AAOS; AOFAS; APMA					
CPT Code:	27647					
Sample Size:	100	**Resp N:**	30	**Response:** 30.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**1.00**	3.00	10.00
Survey RVW:		10.60	18.65	**20.10**	25.00	45.00
Pre-Service Evaluation Time:				**65.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		80.00	120.00	**144.00**	180.00	360.00
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	27647	**Recommended Physician Work RVU: 20.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**43.00**	**33.00**	**10.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**144.00**		
Immediate Post Service-Time:	**30.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27580	090	20.90	**RUC Time**

CPT Descriptor Arthrodesis, knee, 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	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 33.3 %

TIME ESTIMATES (Median)	**CPT Code: 27647**	**Key Reference CPT Code: 27580**	**Source of Time RUC Time**
Median Pre-Service Time	78.00	60.00	
Median Intra-Service Time	144.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	79.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**469.00**	**450.00**	
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	4.78	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	3.89
Urgency of medical decision making	4.67	3.22

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	4.22
Physical effort required	4.22	4.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.56	4.00
Outcome depends on the skill and judgment of physician	4.67	4.11
Estimated risk of malpractice suit with poor outcome	4.33	4.22

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.56	3.56
Intra-Service intensity/complexity	4.33	4.11
Post-Service intensity/complexity	4.33	3.56

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all

of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: Add 10 minutes for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with reconstructive surgeon.
- Positioning: Add 17 minutes for prone positioning.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey median RVW of 20.10. Along with the recommended time and visit information, this results in an IWPUT of 0.071. This RVW is similar to the reference code 27580 which has very similar total work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 27647

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

pecialty 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. national, non-medicare, frequency not available

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? 167
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 65 Percentage 38.92 %

Specialty podiatry Frequency 100 Percentage 59.88 %

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:28171 Tracking Number P90 Specialty Society Recommended RVU: **16.25**

Global Period: 090 RUC Recommended RVU: **16.25**

CPT Descriptor: Radical resection of tumor; tarsal (except talus or calcaneus)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male presents with a giant cell tumor with complete destruction of the cuboid bone and a soft tissue mass. A radical resection of the tumor is performed with excision of the cuboid and the soft tissue mass with preservation of the foot.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 3% , Kept overnight (less than 24 hours) 40% , Admitted (more than 24 hours) 57%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 42%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies with special attention to review of x-ray, CT, MRI, MRA, as well as consulting with radiology regarding margins. Communicate with vascular and/or plastic surgeon regarding operative plan and future reconstruction. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with patient lateral positioning. Assess position of the extremities and head, adjust as needed. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A 6 cm incision is made over the lateral aspect of the foot over the distal calcaneus and cuboid bones. Subcutaneous flaps are raised. The deep fascia is split and the cuboid and its soft tissue mass are exposed. The calcaneocuboid joint is exposed. The cuboid – metatarsal joints are exposed. The peroneal tendons are retracted out of the way. The distal sural nerve is protected. Wide resection of the tumor is performed around the m to the navicular bone medially. Surrounding tissue is sent for margins along with the tumor to pathology for froz section. The pathology report is received and additional tissue is removed as necessary. The wound is inspected and irrigated. The tourniquet is deflated and hemostasis is obtained. A deep drain is placed. The deep tissue is closed with interrupted sutures. The superficial wound is closed in layers with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status... Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management reconstruction. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Rob Mothershedd, DPM; Timothy Tillo, DPM				
Specialty(s):	MSTS; AAOS; AAOS; APMA				
CPT Code:	28171				
Sample Size:	100	**Resp N:**	30	**Response:** 30.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	10.00
Survey RVW:	10.36	16.25	**19.00**	25.00	40.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	75.00	101.00	**120.00**	159.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28171	**Recommended Physician Work RVU: 16.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**43.00**	**33.00**	**10.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

's this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27580	090	20.90	**RUC Time**

CPT Descriptor Arthrodesis, knee, 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	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 23.3 %

TIME ESTIMATES (Median)	CPT Code: 28171	Key Reference CPT Code: 27580	Source of Time RUC Time
Median Pre-Service Time	78.00	60.00	
Median Intra-Service Time	120.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	79.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**365.00**	**450.00**	
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	4.43	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	4.00
Urgency of medical decision making	4.00	3.43

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	4.14
Physical effort required	4.14	4.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.29	4.00
Outcome depends on the skill and judgment of physician	4.57	4.43
Estimated risk of malpractice suit with poor outcome	4.57	4.43

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.14	3.71
Intra-Service intensity/complexity	4.29	4.29
Post-Service intensity/complexity	4.00	3.57

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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: Add 10 minutes for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with reconstructive surgeon.
- Positioning: Add 17 minutes for lateral positioning.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey 25th percentile RVW of 16.25. Along with the recommended time and visit information, this results in an IWPUT of 0.077. This RVW is less than the reference code 27580 which has more intra-operative time and post work, but similar intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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) 28171

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 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. national, non-medicare, frequency not available

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? 41
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 3 Percentage 7.31 %

Specialty podiatry Frequency 35 Percentage 85.36 %

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:28173 Tracking Number P91 Specialty Society Recommended RVU: **14.00**

Global Period: 090 RUC Recommended RVU: **14.00**

CPT Descriptor: Radical resection of tumor; metatarsal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents with a chondrosarcoma of her first metatarsal with a small soft tissue mass. A radical resection of the first metatarsal and the mass is performed with preservation of the great toe.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 3% , Kept overnight (less than 24 hours) 60% , Admitted (more than 24 hours) 33%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 61%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Verify that all required instruments and supplies are available. Assist with patient supine positioning and padding to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A seven cm incision is made excising the previous biopsy tract to keep it with the specimen. Subcutaneous flaps are raised. The sensory nerves are retracted carefully. The extensor tendons are retracted and carefully protected. The metatarsal -navicular joint is identified and isolated. The metatarsal- phalangeal joint is isolated and protected. A wide dissection is carried around the metatarsal with the chondrosarcoma. The plantar neurovascular bundles are identified and retracted. The plantar flexor tendons are retracted. The tumor is removed through the two joints including the joint capsules. Surrounding tissue is sent for frozen section along with the tumor to pathology. Any additional resection will be performed pending the report of the frozen sections results. The wound is then inspected and irrigated. A deep drain is placed. The tourniquet is let down and hemostasis is achieved. Deep 'osure is performed with interrupted sutures. Superficial closure is performed with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room. After patient is awake, discuss surgery outcome with patient. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Dictate operative report and complete medical record documentation. Later on the day of surgery, review

medical records and interval data charted. Communicate with other professionals and with patient and patient's family. Perform an expanded problem focused exam, assessing open wound status and drain. Assess neurovascular status... Consider relevant data, options, and risks and revise treatment plan as necessary. The next day, review medical records and interval data charted. Examine and talk with patient. Take down dressings, asses wound and patient status, make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professio including home restrictions (ie, activity, bathing). Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write order for antibiotic and pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period. Remove dressings, assess wound healing, and redress wound. Remove sutures and drain when appropriate. Discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management reconstruction. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Rob Mothershedd, DPM; Timothy Tillo, DPM
Specialty(s):	MSTS; AAOS; AOFAS; APMA
CPT Code:	28173
Sample Size: 100	**Resp N:** 30 — **Response:** 30.0 %
Sample Type:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	10.00
Survey RVW:	9.87	14.00	**16.00**	20.00	35.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	90.00	**110.00**	140.00	300.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	28173	**Recommended Physician Work RVU: 14.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**110.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
28715	090	14.40	**RUC Time**

CPT Descriptor Arthrodesis; triple

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 26.6 %

TIME ESTIMATES (Median)	CPT Code: 28173	Key Reference CPT Code: 28715	Source of Time RUC Time
Median Pre-Service Time	27.00	60.00	
Median Intra-Service Time	110.00	130.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	79.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**304.00**	**390.00**	
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	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	4.00
Urgency of medical decision making	4.00	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	4.00
Physical effort required	4.00	3.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.88
Outcome depends on the skill and judgment of physician	4.38	4.25
Estimated risk of malpractice suit with poor outcome	4.25	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.88	3.75
Intra-Service intensity/complexity	3.88	3.88
Post-Service intensity/complexity	3.75	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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all

of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: no change
- Positioning: Add 2 minutes. Patient's leg is elevated and foot is stabilized. Opposite extremity is padded. Tourniquet is applied.
- Scrub/Dress/Wait: no change

Recommendation: This patient will typically require a drain and will stay overnight in the hospital for monitoring for compartment syndrome. The surgeon will examine the patient later on the day of the procedure. The consensus committee recommends the survey 25th percentile RVW of 14.00. Along with the recommended time and visit information, this results in an IWPUT of 0.071. This RVW is similar to the reference code 28715 which has more intra-operative time but is less intense and complex.

SERVICES REPORTED WITH MULTIPLE 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) 28173

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 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. national, non-medicare, frequency not available

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? 262
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 18 Percentage 6.87 %

Specialty podiatry Frequency 202 Percentage 77.09 %

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:28175 Tracking Number P92 Specialty Society Recommended RVU: **8.13**

Global Period: 090 RUC Recommended RVU: **8.13**

CPT Descriptor: Radical resection of tumor; phalanx of toe

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman presents with a giant cell tumor of the proximal phalanx of the great toe with complete destruction of the phalanx and a small soft tissue mass. A radical resection of the tumor and soft tissue mass is performed with preservation of the great toe.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 66% , Kept overnight (less than 24 hours) 28% , Admitted (more than 24 hours) 7%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 75%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and imaging studies. Meet with patient/family to review planned procedure and post-operative management. The patient is in the supine positioning and padded to stabilize foot. Perform regional block. Indicate areas of skin to be prepped and mark surgical incisions. Place tourniquet. Prep and drape foot. Inflate pneumatic tourniquet. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A 5 cm incision is made over the dorsomedial proximal phalanx of the great toe. Subcutaneous flaps are raised and the deep tissue is exposed. The extensor tendons are retracted laterally. The metatarsal-phalangeal joint is exposed and protected. The interphalangeal joint is exposed and protected. The neurovascular bundle is identified and protected. The deep flexor tendons are mobilized and protected. Careful dissection is carried around the tumor and it is removed en bloc. Frozen section margins are taken from the surrounding tissue. The pathology report is received and any additional tissue is removed as necessary. Inspection and irrigation of the wound is performed. The tourniquet is let down and hemostasis is obtained. Deep closure is performed with interrupted sutures. Superficial closure is performed with interrupted sutures.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative care with recovery room staff. Ta. specimen to pathology, along with the appropriate history and information. The MRI is also shown to the pathologist to coordinate orientation of the specimen and location. Discuss surgery outcome with patient's family. Write brief operative note and medication orders. Monitor patient stabilization in the recovery room and neurovascular status of the operated extremity. After patient is awake, discuss surgery outcome with patient. Dictate operative report and complete

medical record documentation. Communicate with other professionals and with patient and patient's family. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient, family and other healthcare professionals, including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management. Inform the primary care or referring physician of discharge plans. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms. The patient will be examined in the office several times through the 90-day global period to remove dressings, assess wound healing, assess neurovascular status and redress wound; remove sutures; and discuss pathology report when available. Order and review periodic lab and/or imaging, as necessary. Order occupational or physical therapy and assess functional recovery. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management for reconstruction and further chemo/radiation therapy. Discuss progress with oncologist and PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	John Heiner, MD; William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Robb Mothershedd, DPM; Timothy Tillo, DPM				
Specialty(s):	MSTS; AAOS; AOFAS; APMA				
CPT Code:	28175				
Sample Size:	100	**Resp N:**	30	**Response:**	30.0 %
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	2.00	20.00
Survey RVW:	6.73	8.13	**9.45**	12.28	19.20
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	40.00	45.00	**60.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-Straightforward Pat Procedure(w sedation/anes)

CPT Code:	28175	**Recommended Physician Work RVU: 8.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**79.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	090		**RUC Time**	0

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	**CPT Code: 28175**	**Key Reference CPT Code: 29891**	**Source of Time RUC Time**
Median Pre-Service Time	27.00	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	
edian Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	79.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**205.00**	**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	3.67	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	2.83
Urgency of medical decision making	3.83	2.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.33
Physical effort required	2.67	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	2.83
Outcome depends on the skill and judgment of physician	3.67	3.17
Estimated risk of malpractice suit with poor outcome	3.33	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.83	2.83
Intra-Service intensity/complexity	3.00	2.33
Post-Service intensity/complexity	2.33	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.*

Compelling Evidence

The MTS and the AAOS presented the malignant bone tumor codes as misvalued to CMS and the RUC during the last 5-year-review. Although these codes were a subset of all of the tumor codes presented by MTS, and they are only performed by orthopaedic surgeons (and podiatry for some of the foot/toe codes), they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. Subsequent to that decision, the bone tumor codes

had minor revisions made to their descriptors. The same compelling evidence arguments still apply to the review of these codes – a change in patient population, a change in technology, and the fact that the surgeons who most often perform these rarely performed procedures were not part of the Harvard study, which significantly underestimated the work to resect these bone tumors and care for these patients with bone cancer.

Over the past ten years, significant advancement has been made in the treatment of bone tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and (more importantly) functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

Pre-Time: With respect to the pre-service time, we recommend package 1B with the following modifications:

- Evaluation: no change
- Positioning: Add 5 minutes for patient positioning supine, with foot elevated and stabilized with padding (including padding the opposite leg), and application of a tourniquet.
- Scrub/Dress/Wait: no change

Recommendation: The consensus committee recommends the survey 25th percentile RVW of 8.13. Along with the recommended time and visit information, this results in an IWPUT of 0.059. This RVW is less than the reference code 29891 which has similar time and visits, but is more complex and intense intra-operatively and thus has a higher IWPUT (.069) and a commiserate higher RVW of 9.47.

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: 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.

REQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 28175

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 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. national, non-medicare, frequency not available

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? 269
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 13 Percentage 4.83 %

Specialty podiatry Frequency 247 Percentage 91.82 %

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

Date: January 6, 2009

To: William L. Rich, III, MD, FACS, Chair, AMA/Specialty Society RVS Update Committee

From: John Heiner, MD, Musculoskeletal Tumor Society
William Creevy, MD, RUC Advisor, American Academy of Orthopaedic Surgeons
Daniel Nagle, MD, FACS, RUC Advisor, American Society for Surgery of the Hand
Tye Ouzounian, MD, RUC Advisor, American Orthopaedic Foot and Ankle Society
Frank Spinosa, DPM, HCPAC Advisor, American Podiatric Medical Association

Subject: RUC Work Value Recommendations for Bone Tumor Codes

Introduction

On behalf of the Musculoskeletal Tumor Society (MSTS), American Academy of Orthopaedic Surgeons (AAOS), American Society for Surgery of the Hand (ASSH), American Orthopaedic Foot and Ankle Society (AOFAS), and the American Podiatric Medical Association (APMA) are pleased to provide (after 14 years of on-going work) physician work RVU recommendations for excision of bone tumor codes as identified in the RUC agenda for Jan/Feb 2009 Tab 8:

P57-26262	P90-28171	P82-27646	P74-27365
P92-28175	P41-24152	P40-24150	P67-27078
P56-26260	P83-27647	P81-27645	P64-27075
P91-28173	P48-25170	P32-23210	P65-27076
P55-26250	P31-23200	P33-23220	P66-27077

In 1993, eight codes for resection of bone tumors were brought to CPT for editorial changes (27075, 27365, 27645, 27646, 27647, 28171, 28173, and 28175). These were part of the extensive revision to the musculoskeletal section of CPT. No RUC surveys were conducted.

Of the 20 malignant bone tumor codes, only one code was surveyed during the Harvard study for all components (pre, intra, and post), and the survey consisted of only six general orthopaedic surgeons. The other 19 codes were only surveyed for intra-operative time/work, with pre and post-service work predicted by algorithm. The current Medicare frequency for these codes ranges from a low of four to a high of 417, with most of the codes performed less than 100 times annually. We believe it is fair to say that the six general orthopaedic surgeons surveyed during the Harvard study were not likely familiar and fit to rate these major procedures that are most often referred to musculoskeletal tumor specialists.

In 1994, the AAOS responded to CMS's first 5-year review request for comment on misvalued codes with a letter that included approximately 1,300 codes. Because a significant portion of the musculoskeletal section of CPT were in an extensive revision process at the same time the Harvard Study results were being sent to CMS for the first physician fee schedule, codes were incorrectly crosswalked and anomalies were created. The comment letter included the results of an Abt study, similar to the Harvard study methodology. The AAOS presented this study to the AMA/RUC Research Subcommittee and it was rejected. The AAOS was allowed to withdraw the original comment and submit a modest list of 83 codes believed to be "most" misvalued for survey and review during the first 5-year review.

Two of the 83 codes were for radical resection of bone tumors (27076 and 27365). The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate the intra-operative work. Total work, intra-operative intensity, and levels of hospital and office visits were not considered. New work values were calculated by adding an additional RVU increment to account for the different in intra-operative time between the Harvard study and the RUC survey. The calculated work RVU's resulted in an IWPUT of 0.022 for both codes. If the level of hospital visits are considered and corrected, a

negative IWPUT results. The current survey provides time and visit data from surgeons familiar with these procedures. Intra-operative time for both codes is significantly greater than recorded in 1995. For this reason, we are asking for these codes to be reviewed at this time for all survey components (pre, intra, post)

Two additional codes were submitted by the MSTS and the AAOS for review during the second 5-year-review (27075 and 27077). During this review of physician work, the RUC reviewed all components of work. The RUC agreed that the patient population had become more complex and that the Harvard study did not correctly estimate physician work for these codes. During the current survey process, we find that the intra-operative time and length of stay has decreased slightly for 27075 and has increased slightly for 27077. For this reason, we are asking for these codes to be reviewed, as we are recommending that the work RVUs for 27075 be decreased slightly and the work RVUs for 27077 be increased slightly.

Significant advancement in imaging has allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas. As such, whereas in the past only small lesions were amenable to resection, now very large tumors are resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk.

The Musculoskeletal Tumor Society and the AAOS have presented bone tumor codes to CMS and the RUC during at least one of three 5-year-reviews. The most recent 5-year-review outcome was to send the issue to CPT for coding changes before reviewing work changes.

Methodology

The MSTS and the AAOS, along with the ASSH, AOFAS, and APMA conducted a full RUC survey for each of the 20 bone tumor codes, with varying involvement. Surveying specialties for each code are shown the SoRs. Multiple conference calls before, during and after the survey process were held to be certain everyone was involved. We attempted to identify surgeons familiar with the procedures to survey and except for some of the very low volume codes, a minimum of 30 survey responses was obtained and almost all respondents had experience for the codes they were reviewing.

In developing our recommendations for pre-service time, we utilized the pre-time packages. For some codes, we also added time in a standardized fashion for positioning beyond supine (eg, prone, lateral, beach chair). For each code, a description of pre-time changes (additions and subtractions) is presented in the rationale section.

Frequency and Impact

None of the 20 codes had a change in CPT code numbering. The Medicare frequency is not expected to be different based on CPT nomenclature changes.

One recommendation is less than the current RVW. The Medicare impact for the bone tumor code recommendations would be a net increase of approximately $500,000.

Summary

Although these codes were a subset of all of the codes presented by the MSTS at the last 5-year-review, they were put on hold until all of the soft tissue and bone tumor codes could be reviewed at CPT. For these reasons,

and the compelling evidence arguments discussed above, we request that the RUC agree to review all of these bone tumor codes under the 5-year-review of physician work rules.

Attachments

Attachment A-Radical Bone Tumor Codes Summary File
Attachment B-Radical Bone Tumor Codes With Key References Summary File
Attachment C-Bone Tumor Codes History Summary

TABLE 1: Radical Excision of Bone Tumor - Recommendations

Descriptor			5-Year	RUC	2010	2009	2009	2010	RUC RECOMMENDATION			RVW					Total	PRE	PRE				POST-HOSPITAL									POST-OFFICE		
ID	CPT	Radical resection of tumor,	Review	Valued	Util	RVW	RVUs	RVUs	STAT	RVW	IWPUT	MIN	25TH	MED	75TH	MAX	Time	PKG	EVAL	POSIT	SDW	INTRA	P-SD	SOS	LOS	SD-V	LOS	99231	99232	99238	OV	99212	99213	99214
P31	23200	clavicle	Y	N	36	12.69	457	810	med	22.50	0.077	16.00	20.00	22.50	28.50	35.00	497	4	40	12	20	155	30	FAC	ADM	YES	4	1	2	1	4	1	2	1
P32	23210	scapula	Y	N	35	13.16	461	945	25th	27.00	0.078	23.00	27.00	30.00	30.00	45.00	560	4	40	20	20	210	30	FAC	ADM	YES	4	1	2	1	4	1	2	1
P33	23220	proximal humerus	Y	N	41	15.36	630	1,230	25th	30.00	0.078	23.00	30.00	32.50	35.00	50.00	602	4	40	12	20	240	30	FAC	ADM	YES	5	2	2	1	4	1	2	1
P40	24150	shaft or distal humerus	Y	N	85	13.70	1,165	1,976	med	23.25	0.074	14.00	22.00	23.25	30.00	45.00	502	4	40	12	20	180	30	FAC	ADM	YES	4	2	1	1	4	1	2	1
P41	24152	radial head or neck	Y	N	4	10.24	41	79	25th	19.78	0.072	14.30	19.78	22.00	27.38	40.00	440	3	33	12	15	150	30	FAC	ADM	YES	3	1	1	1	4	1	2	1
P48	25170	radius or ulna	Y	N	30	11.34	340	660	med	22.00	0.073	10.00	20.00	22.00	29.63	45.00	470	3	33	12	15	180	30	FAC	ADM	YES	3	1	1	1	4	1	2	1
P55	26250	metacarpal	N	N	23	7.61	175	345	med	15.00	0.065	7.00	14.00	15.00	22.00	40.00	353	2B	23	10	15	120	25	FAC	ADM	YES	2	1		1	4	1	2	1
P56	26260	proximal or middle phalanx of finger	N	N	28	7.09	199	308	25th	11.00	0.070	8.00	11.00	12.00	20.00	40.00	256	2B	23	10	15	90	20	FAC	SD	NO	0.5			0.5	3	1	1	1
P57	26262	distal phalanx of finger	N	N	32	5.72	183	260	blend	8.13	0.061	5.90	8.00	9.00	11.00	27.00	212	1B	14	10	10	60	20	FAC	SD	NO	0.5			0.5	3	1	1	1
P64	27075	wing of ilium, one pubic or ischial ramus or symphysis pubis	N	Y	82	36.77	3,015	2,665	med	32.50	0.083	20.00	27.25	32.50	37.75	50.00	633	4	40	3	20	240	30	FAC	ADM	YES	6	2	3	1	4	1	2	1
P65	27076	ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Y	Y	89	24.25	2,158	3,560	med	40.00	0.069	5.00	40.00	40.00	45.00	90.00	840	4	40	20	20	360	40	FAC	ADM	YES	8	3	4	1	4	1	2	1
P66	27077	innominate bone, total	N	Y	6	42.54	255	270	med	45.00	0.072	35.00	40.00	45.00	49.00	60.00	905	4	40	20	20	400	45	FAC	ADM	YES	9	4	4	1	4	1	2	1
P67	27078	ischial tuberosity and greater trochanter of femur	Y	N	55	14.54	800	1,760	med	32.00	0.078	20.00	29.00	32.00	40.00	50.00	665	4	40	20	20	240	45	FAC	ADM	YES	6	2	3	1	4	1	2	1
P74	27365	femur or knee	Y	Y	417	17.93	7,477	13,344	med	32.00	0.081	25.00	30.00	32.00	36.00	45.00	633	4	40	3	20	240	30	FAC	ADM	YES	6	2	3	1	4	1	2	1
P81	27645	tibia	Y	N	59	14.78	872	1,593	med	27.00	0.080	17.61	25.00	27.00	35.00	60.00	553	4	40	3	20	200	30	FAC	ADM	YES	5	2	2	1	4	1	2	1
P82	27646	fibula	Y	N	31	13.21	410	713	med	23.00	0.067	10.63	23.00	23.00	28.00	50.00	540	4	40	20	20	180	40	FAC	ADM	YES	4	1	2	1	4	1	2	1
P83	27647	talus or calcaneus	Y	N	167	12.85	2,146	3,357	med	20.10	0.071	10.60	18.65	20.10	25.00	45.00	469	3	43	20	15	144	30	FAC	ADM	YES	4	1	2	1	3	1	1	1
P90	28171	tarsal (except talus or calcaneus)	N	N	41	9.85	404	666	25th	16.25	0.077	10.38	16.25	19.00	25.00	40.00	365	3	43	20	15	120	30	FAC	ADM	YES	2	1		1	3	1	1	1
P91	28173	metatarsal	N	N	262	9.05	2,371	3,668	25th	14.00	0.072	9.87	14.00	16.00	20.00	35.00	307	1B	19	3	5	110	30	FAC	ADM	YES	2	1		1	3	1	1	1
P92	28175	phalanx of toe	N	N	269	6.17	1,660	2,187	25th	8.13	0.061	6.73	8.13	9.45	12.28	19.20	208	1B	19	3	5	60	20	FAC	SD	NO	0.5			0.5	3	1	1	1

TABLE 2: Excision of Radical Bone Tumor Codes with Survey References

Util	SOURCE	ID	CPT	Descriptor	glob	2009 RVW	RUC REC	IWPUT	TOTAL Time	Hosp vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP P-SD	POST-HOSP 32	POST-HOSP 31	POST-HOSP 38	POST-HOSP 39	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11
82	REF	RUC	25651	Percutaneous sk	90	5.68	5.68	0.040	190	0.5	4	50			30	20			0.5				1	3	
3,525	REF	RUC	28288	Ostectomy, parti	90	5.81	5.81	0.035	169	0	5	20			30	20							4		1
50,017	REF	RUC	20680	Removal of impl	90	5.90	5.90	0.056	181	0.5	2	35	15	15	50	15			0.5					2	
362	REF	RUC	27347	Excision of lesio	90	6.58	6.58	0.032	214	0	3	45			60	40							3		
26	REF	RUC	25109	Excision of tend	90	6.81	6.81	0.063	191	0.5	3	25	10	15	40	20			0.5				2	1	
34	REF	RUC	24332	Tenolysis, tricep	90	7.77	7.77	0.051	230	0.5	4	50			60	30			0.5				1	3	
11,280	REF	RUC	25606	Percutaneous sk	90	8.10	8.10	0.042	260	0.5	5	40	10	15	45	30			0.5				3	2	
2,715	REF	RUC	28289	Hallux rigidus co	90	8.11	8.11	0.069	197	0	4	30			45	30							4		
269	**Survey**	**Survey**	**28175**	**Radical resectio**	**90**	**6.17**	**8.13**	**0.061**	**208**	**0.5**	**3**	**19**	**6**	**5**	**60**	**20**			**0.5**			**1**	**1**	**1**	
32	**Survey**	**Survey**	**26262**	**Radical resectio**	**90**	**5.72**	**8.13**	**0.061**	**212**	**0.5**	**3**	**14**	**10**	**10**	**60**	**20**			**0.5**			**1**	**1**	**1**	
5,522	REF	RUC	24685	Open treatment	90	8.21	8.21	0.047	252	0.5	4	40	15	10	60	30			0.5				2	2	
4,402	REF	RUC	28750	Arthrodesis, grea	90	8.37	8.37	0.042	237	0	4	40			75	30							4		
26,997	REF	RUC	29824	Arthroscopy, sho	90	8.81	8.81	0.065	225	0.5	4	48			60	20			0.5				2	2	
29	REF	RUC	29860	Arthroscopy, hip	90	8.85	8.85	0.053	244	0	3	75			70	30							3		
82	REF	RUC	24345	Repair medial co	90	8.99	8.99	0.041	284	0.5	5	58			90	30			0.5				1	4	
1,693	REF	RUC	28740	Arthrodesis, mid	90	9.09	9.09	0.039	266	0.5	4	45			80	30			0.5				4		
2,680	REF	RUC	25607	Open treatment	90	9.35	9.35	0.052	275	0.5	5	40	10	15	60	30			0.5				3	2	
335	REF	MPC	29891	Arthroscopy, ank	90	9.47	9.47	0.069	227	0	4	50			60	25							4		
24	REF	RUC	24582	Percutaneous sk	90	9.89	9.89	0.043	295	0	5	60			60	60							5		
12	REF	RUC	25394	Osteoplasty, car	90	10.71	10.71	0.069	250	0.5	4	50			90	20			0.5				1	3	
10,776	REF	RUC	25447	Arthroplasty, inte	90	10.95	10.95	0.058	278	0.5	5	20	15	10	100	20			0.5				2	3	
405	REF	MPC	29862	Arthroscopy, hip	90	10.97	10.97	0.049	297	0	4	75			100	30							4		
28	**Survey**	**Survey**	**26260**	**Radical resectio**	**90**	**7.09**	**11.00**	**0.070**	**256**	**0.5**	**3**	**23**	**10**	**15**	**90**	**20**			**0.5**			**1**	**1**	**1**	
3,205	REF	RUC	28293	Correction, hallu	90	11.10	11.10	0.035	318	0	7	30			80	30						1	6		
171	REF	RUC	27894	Decompression	90	12.42	12.42	0.008	433	6	5	60			90	30		5	1				5		
6,620	REF	RUC	28805	Amputation, foot	90	12.55	12.55	0.040	376	7	4	30	15	15	60	20		6	1				2	2	
New	REF	RUC	29828	Arthroscopy, sho	90	13.00	13.00	0.104	262	0.5	4	40	15	15	75	20			0.5				2	2	
262	**Survey**	**Survey**	**28173**	**Radical resectio**	**90**	**9.05**	**14.00**	**0.070**	**307**	**2**	**3**	**19**	**6**	**5**	**110**	**30**		**1**	**1**			**1**	**1**	**1**	
1,781	REF	RUC	28715	Arthrodesis; tripl	90	14.40	14.40	0.045	390	3	4	60			130	30		2	1				4		
3,751	REF	RUC	29807	Arthroscopy, sho	90	14.48	14.48	0.097	288	0.5	5	55			90	30			0.5				2	3	
1,022	REF	RUC	29806	Arthroscopy,	90	14.95	14.95	0.092	298	0.5	5	55			100	30			0.5				2	3	
23	**Survey**	**Survey**	**26250**	**Radical resectio**	**90**	**7.61**	**15.00**	**0.065**	**353**	**2**	**4**	**23**	**10**	**15**	**120**	**25**		**1**	**1**			**1**	**2**	**1**	
2,850	REF	MPC	27870	Arthrodesis, ank	90	15.22	15.22	0.048	400	3	4	60			140	30		2	1				4		

TABLE 2: Excision of Radical Bone Tumor Codes with Survey References

Util	SOURCE	ID	CPT	Descriptor	glob	2009 RVW	RUC REC	IWPUT	TOTAL Time	Hosp vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP P-SD	POST-HOSP 32	POST-HOSP 31	POST-HOSP 38	POST-HOSP 39	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11
16,670	REF	RUC	27880	Amputation, leg,	90	15.24	15.24	0.061	400	7	3	30	15	15	80	20	1	5	1				2	1	
41	**Survey**	**Survey**	**28171**	**Radical resecti**	**90**	**9.85**	**16.25**	**0.077**	**365**	**2**	**3**	**43**	**20**	**15**	**120**	**30**		**1**	**1**			**1**	**1**	**1**	
76,411	REF	RUC	27236	Open treatment	90	17.43	17.43	0.060	473	6	4	60	15	15	90	30	2	3	1				3	1	
NEW	REF	RUC	28446	Open osteochon	90	17.5	17.5	0.091	339	1	5	45	10	10	120	15			1				3	2	
364	REF	MPC	23395	Muscle transfer,	90	18.29	18.29	0.060	423	2	5	60			160	30		1	1				5		
430	REF	RUC	27724	Repair of nonuni	90	19.18	19.18	0.060	460	3	3	90			180	30	1	1	1				2	1	
4	**Survey**	**Survey**	**24152**	**Radical resecti**	**90**	**10.24**	**19.78**	**0.072**	**440**	**3**	**4**	**33**	**12**	**15**	**150**	**30**	**1**	**1**	**1**			**1**	**2**	**1**	
167	**Survey**	**Survey**	**27647**	**Radical resecti**	**90**	**12.85**	**20.10**	**0.071**	**469**	**4**	**3**	**43**	**20**	**15**	**144**	**30**	**2**	**1**	**1**			**1**	**1**	**1**	
388	REF	RUC	28705	Arthrodesis; pan	90	20.12	20.12	0.058	490	3	4	75			180	35	1	1	1			1	2	1	
1,150	REF	MPC	22595	Arthrodesis,	90	20.44	20.44	0.074	492		4	90			150	160							4		
467	REF	RUC	27580	Arthrodesis, kne	90	20.90	20.90	0.073	450	5	4	60			150	30		4	1				4		
103,279	REF	RUC	27130	Arthroplasty, ace	90	21.61	21.61	0.081	478	5	4	60	15	15	135	30	1	3	1				3	1	
30	**Survey**	**Survey**	**25170**	**Radical resecti**	**90**	**11.34**	**22.00**	**0.073**	**470**	**3**	**4**	**33**	**12**	**15**	**180**	**30**	**1**	**1**	**1**			**1**	**2**	**1**	
12,726	REF	RUC	23472	Arthroplasty, gle	90	22.47	22.47	0.079	458	4	4	60			165	30	1	2	1				3	1	
1,035	REF	MPC	24363	Arthroplasty, elb	90	22.47	22.47	0.085	466	4	4	50	17.5	15	150	30	1	2	1				3	1	
36	**Survey**	**Survey**	**23200**	**Radical resecti**	**90**	**12.69**	**22.50**	**0.077**	**497**	**4**	**4**	**40**	**12**	**20**	**155**	**30**	**2**	**1**	**1**			**1**	**2**	**1**	
31	**Survey**	**Survey**	**27646**	**Radical resecti**	**90**	**13.21**	**23.00**	**0.067**	**540**	**4**	**4**	**40**	**20**	**20**	**180**	**40**	**2**	**1**	**1**			**1**	**2**	**1**	
251,893	REF	RUC	27447	Arthroplasty, kne	90	23.04	23.04	0.099	469	5	4	45	15	15	124	30	1	3	1			1	2	1	
85	**Survey**	**Survey**	**24150**	**Radical resecti**	**90**	**13.70**	**23.25**	**0.074**	**502**	**4**	**4**	**40**	**12**	**20**	**180**	**30**	**1**	**2**	**1**			**1**	**2**	**1**	
59	REF	RUC	23222	Radical resectior	90	25.14	25.14	0.062	560	5	4	80			240	30		4	1				4		
19	REF	RUC	22319	Open treatment	90	25.15	25.15	0.100	483	4	4	120			150	30		3	1				3	1	
71	REF	RUC	22548	Arthrodesis, ante	90	26.86	26.86	0.096	532		4	100			180	160							4		
12,537	REF	RUC	27487	Revision of total	90	26.91	26.91	0.081	520	6	4	60			200	30		5	1				4		
59	**Survey**	**Survey**	**27645**	**Radical resecti**	**90**	**14.78**	**27.00**	**0.080**	**533**	**5**	**4**	**40**	**3**	**20**	**200**	**30**	**2**	**2**	**1**			**1**	**2**	**1**	
35	**Survey**	**Survey**	**23210**	**Radical resecti**	**90**	**13.16**	**27.00**	**0.078**	**560**	**4**	**4**	**40**	**20**	**20**	**210**	**30**	**2**	**1**	**1**			**1**	**2**	**1**	
225	REF	RUC	22808	Arthrodesis, ante	90	27.31	27.31	0.096	553			90			180	191							4		
501	REF	RUC	27228	Open treatment	90	29.13	29.13	0.055	680	6	4	80			300	30	1	5	1				4		
41	**Survey**	**Survey**	**23220**	**Radical resecti**	**90**	**15.36**	**30.00**	**0.078**	**602**	**5**	**4**	**40**	**12**	**20**	**240**	**30**	**2**	**2**	**1**			**1**	**2**	**1**	
10,707	REF	MPC	27134	Revision of total	90	30.13	30.13	0.074	617	8	3	90			240	40		7	1				3		
5	REF	RUC	20824	Replantation, thu	90	31.74	31.74	0.066	646		5	60			360	125							3	2	
417	**Survey**	**Survey**	**27365**	**Radical resecti**	**90**	**17.93**	**32.00**	**0.081**	**633**	**6**	**4**	**40**	**3**	**20**	**240**	**30**	**3**	**2**	**1**			**1**	**2**	**1**	
55	**Survey**	**Survey**	**27078**	**Radical resecti**	**90**	**14.54**	**32.00**	**0.078**	**665**	**6**	**4**	**40**	**20**	**20**	**240**	**45**	**3**	**2**	**1**			**1**	**2**	**1**	
82	**Survey**	**Survey**	**27075**	**Radical resecti**	**90**	**36.77**	**32.50**	**0.083**	**633**	**6**	**4**	**40**	**3**	**20**	**240**	**30**	**3**	**2**	**1**			**1**	**2**	**1**	

TABLE 2: Excision of Radical Bone Tumor Codes with Survey References

Util	SOURCE	ID	CPT	Descriptor	glob	2009 RVW	RUC REC	IWPUT	TOTAL Time	Hosp vis	Off vis	PRE EVAL	PRE POSIT	PRE SDW	INTRA	POST-HOSP P-SD	POST-HOSP 32	POST-HOSP 31	POST-HOSP 38	POST-HOSP 39	POST-OFFICE 15	POST-OFFICE 14	POST-OFFICE 13	POST-OFFICE 12	POST-OFFICE 11
13	REF	RUC	22819	Kyphectomy, circ	90	39.18	39.18	0.088	795	10	4	120			245	60	3	6	1				4		
89	**Survey**	**Survey**	**27076**	**Radical resectio**	**90**	**24.25**	**40.00**	**0.069**	**840**	**8**	**4**	**40**	**20**	**20**	**360**	**40**	**4**	**3**	**1**			**1**	**2**	**1**	
115	REF	MPC	20955	Bone graft with r	90	40.02	40.02	0.062	867		6	100			480	170							3	3	
50	REF	RUC	20956	Bone graft with r	90	40.93	40.93	0.063	894	10	7	90			400	60		9	1				2	5	
5	REF	RUC	20957	Bone graft with r	90	42.33	42.33	0.063	930	10	8	90			420	60		9	1				2	6	
6	**Survey**	**Survey**	**27077**	**Radical resectio**	**90**	**42.54**	**45.00**	**0.072**	**905**	**9**	**4**	**40**	**20**	**20**	**400**	**45**	**4**	**4**	**1**			**1**	**2**	**1**	

CPT Code: See Below
Specialty Society('s) AAOS, ACS, AOFAS, APMA, ASPS, AAOHNS

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

P31	23200	Radical resection of tumor; clavicle
P32	23210	Radical resection of tumor; scapula
P33	23220	Radical resection of tumor, proximal humerus
P40	24150	Radical resection of tumor, shaft or distal humerus
P41	24152	Radical resection of tumor, radial head or neck
P48	25170	Radical resection of tumor, radius or ulna
P55	26250	Radical resection of tumor, metacarpal
P56	26260	Radical resection of tumor, proximal or middle phalanx of finger
P57	26262	Radical resection of tumor, distal phalanx of finger
P64	27075	Radical resection of tumor; wing of ilium, one pubic or ischial ramus or symphysis pubis
P65	27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum
P66	27077	Radical resection of tumor; innominate bone, total
67	27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur
P74	27365	Radical resection of tumor, femur or knee
P81	27645	Radical resection of tumor; tibia
P82	27646	Radical resection of tumor; fibula
P83	27647	Radical resection of tumor; talus or calcaneus
P90	28171	Radical resection of tumor; tarsal (except talus or calcaneus)
P91	28173	Radical resection of tumor; metatarsal
P92	28175	Radical resection of tumor; phalanx of toe

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 committee of orthopaedic surgeons, foot and ankle orthopaedic surgeons, and podiatrists representing all types of practices and all geographic settings discussed the practice expense details for the new codes shown above. The consensus was that none of these procedures are emergent.

CPT Code: See Below
Specialty Society('s) AAOS, ACS, AOFAS, APMA, ASPS, AAOHNS

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management (standard 6 minutes for same day or 12 minutes for overnight/admit) and standard office visit related activities are performed.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				P31	P32	P33	P40	P41	P48	P55	P56	P57	P64
2	**AMA/Specialty Society RVS Update Committee Recommendation**			23200	23210	23220	24150	24152	25170	26250	26260	26262	27075
3				Radical Resection of tumor; clavicle	Radical Resection of tumor; scapula	Radical Resection of tumor; proximal humerus	Radical Resection of tumor; shaft or distal humerus	Radical Resection of tumor; radial head or neck	Radical Resection of tumor; radius or ulna	Radical Resection of tumor; metacarpal	Radical Resection of tumor; proximal or middle phalanx of finger	Radical Resection of tumor; distal phalanx of finger	Radical Resection of tumor; wing of ilium, one pubic or ischial ramus or symphysis pubis
4	**LOCATION**	**Code**	**Staff Type**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**218**	**218**	**218**	**218**	**218**	**212**	**218**	**182**	**182**	**218**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**6**	**6**	**6**	**6**	**6**	**0**	**6**	**6**	**6**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**152**	**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**152**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	**6**	**6**	**6**	**6**	**6**	**0**	**6**	**6**	**6**	**6**
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
49	99213 36 minutes		36	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**1**	**1**	**2**
50	99214 53 minutes		53	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**152**	**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**152**
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**3**	**3**	**4**
58	pack, post-op incision care (suture)	**SA054**	**pack**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
59	**Equipment**	**Code**											
60	table, power	**EF031**		**152**	**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**152**
61	light, surgical	**EF014**		**152**	**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**152**

1320

	A	B	C	N	O	P	Q	R	S	T	U	V	W
1				P65	P66	P67	P74	P81	P82	P83	P90	P91	P92
2	**AMA/Specialty Society RVS Update Committee Recommendation**			27076	27077	27078	27365	27645	27646	27647	28171	28173	28175
3				Radical Resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Radical Resection of tumor; innominate bone, total	Radical Resection of tumor; ischial tuberosity and greater trochanter of femur	Radical Resection of tumor; femur or knee	Radical Resection of tumor; tibia	Radical Resection of tumor; fibula	Radical Resection of tumor; talus or calcaneus	Radical Resection of tumor; tarsal (except talus or calcaneus)	Radical Resection of tumor; metatarsal	Radical Resection of tumor; phalanx of toe
4	**LOCATION**	**Code**	**Staff Type**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**	**FAC only**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**218**	**218**	**218**	**224**	**224**	**224**	**188**	**188**	**182**	**188**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**6**	**6**	**6**	**12**	**12**	**12**	**12**	**12**	**6**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**116**	**116**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
18	**End:When patient enters office/facility for surgery/procedure**												
19	**SERVICE PERIOD**												
20	**Start: When patient enters site for procedure: Services Prior to Procedure**												
39	Discharge day management	**L037D**	RN/LPN/MTA	**6**	**6**	**6**	**12**	**12**	**12**	**12**	**12**	**6**	**12**
41	**End: Patient leaves office**												
42	**POST-SERVICE Period**												
43	**Start: Patient leaves office/facility**												
46	*List Number and Level of Office Visits*												
47	99211 16 minutes		16										
48	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
49	99213 36 minutes		36	**2**	**2**	**2**	**2**	**2**	**2**	**1**	**1**	**1**	**1**
50	99214 53 minutes		53	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
51	99215 63 minutes		63										
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**116**	**116**
55	**End: with last office visit before end of global period**												
56	**MEDICAL SUPPLIES**	**Code**	**Unit**										
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**4**	**4**	**4**	**4**	**4**	**4**	**3**	**3**	**3**	**3**
58	pack, post-op incision care (suture)	**SA054**	**pack**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
59	**Equipment**	**Code**											
60	table, power	**EF031**		**152**	**152**	**152**	**152**	**152**	**152**	**116**	**116**	**116**	**116**
61	light, surgic	**EF014**		**152**		**152**	**152**	**152**	**152**	**116**	**116**	**1**	**116**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from the Five Year Review

April 2009

Arteriovenous Shunt Imaging

The RUC identified 36145, *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* and 75790, *Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation* through the Five Year Review Identification Workgroup's Codes Reported Together screen as they are reported together more than 95% of the time and referred to CPT for creation of a new bundled service. At its November 2008 meeting, the CPT Editorial Panel created three new codes to describe the work previously reported in 36145 and 75790. The Panel created: 36147, *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)* to describe the combined service; 36148, *additional access for therapeutic intervention (List separately in addition to code for primary procedure)*, an add-on service to describe instances where the practitioner requires additional access to the arteriovenous shunt; and 75791, *Angiography, arteriovenous shunt (dialysis fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation*, which describes the work previously reported with either 36147 or 75790.

1322

36147

The specialty society presented the results of a survey of 68 vascular surgeons and interventional radiologists. Survey respondents indicated a median intra-service time of 45 minutes, which the specialty society expert panel and the RUC agreed was appropriate. In consideration of the physician time, the RUC noted that the total time of 36145 plus 75790 is 57 minutes (23 minutes and 34 minutes), though these services have never been RUC reviewed. The specialty noted that the typical patient has changed from a patient with a graft to a patient with a fistula. Fistulas are inherently more difficult to manage. Survey respondents also indicated that moderate sedation is inherent, as it is performed 73% of the time. The survey respondents indicated a median work RVU of 4.70, which the specialty expert panel noted was evidence that the typical patient had changed and is now more difficult. However, the specialty expert panel did not agree that this was an appropriate valuation of the work, nor did they feel the survey 25th percentile work RVU was appropriate. Rather, the specialty recommended and the RUC agreed that the appropriate work RVU for 36147 is 3.72 RVUs. To

calculate this value, the RUC reviewed the survey key reference service, 36558, *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (work RVU = 4.81, intra-service time = 30 minutes) and subtracted the value of the post-operative hospital visits within its global period. The visits include one 99212 (0.45) and one-half 99238 (0.64). 4.81 – 1.09 = 3.72. The RUC also noted that the current values of 36145 and 75790 are 2.01 and 1.84 (2.01 + 1.84 = 3.85), respectively and the correct value of 36147 should be slightly lower to account for any efficiencies by performing the procedures together. The RUC also compared the surveyed service to 36145, *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (work RVU = 3.59, intra-service time = 45 minutes) and agreed that the two services are comparable, though 36147 is requires greater intensity, accounting for a slightly higher work RVU. **Therefore, the RUC recommends the new physician time as surveyed and a work RVU of 3.72 for CPT code 36147.**

36148

The specialty society presented the results of a survey of 45 vascular surgeons and interventional radiologists. The societies involved convened an expert panel as the surveyees indicated physician time which included pre and post service work for this add-on service, selected a 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), and indicated a median work RVU of 4.13 for 36148. Survey respondents also indicated that moderate sedation is inherent, as it is performed 74% of the time. The expert panel did not agree that the survey results appropriately reflected the time or work required to perform this procedure. The expert panel instead derived a work value of 1.00 for 36148 by dividing the existing work value of 36145, *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* (work RVU = 2.01) by two. Currently, when an additional access is required, a physician will report an additional 36145, subject to a modifier 51 reduction of 50%. The new add-on code describes the same intra-service work originally reported by 36145, which was subjected to the 50% reduction. As such, the expert panel and the RUC agreed that one-half the current value is appropriate (2.01 / 2 = 1.00). The RUC also reviewed another reference service, 36620, *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous),* (work RVU = 1.15, 7 minutes pre, 10 minutes intra, and 5 minutes post-service time). Though the specialty society agreed that the work of cannulating a poorly functioning dialysis graft or fistula is more difficult than placement of a routine arterial line, the RUC agreed that 36620 represents the most reasonable comparison. The specialties' expert panel posits that respondents may not have understood the complexities of add-on codes and modifier -51 exempt codes, which skewed the physician time and work values. The panel recommended and the RUC agreed that 15 minutes of intra-service time best reflects the time involved for 36148. **Therefore, the RUC recommends a work RVU of 1.00 and an intra-service time of 15 minutes with no pre and post service times for CPT code 36148.**

75791

The specialty society presented the results of a survey of 45 vascular surgeons and interventional radiologists. The survey respondents indicated a median intra-service time of 30 minutes. However, the specialties' expert panel agreed that this was slightly higher than required. The work involved in 75791 represents a very rare scenario. For a 75791, a patient is sent to the physician once dialysis has begun, but the fistula or graft is not functioning properly. The dialysis needle is still in place and the imaging is conducted through that access point. The specialty commented that the overestimation of the intra-service time may also be due to the mix of specialties completing the survey. As such, the specialty recalculated the survey results between interventional radiologists and vascular surgeons based on utilization and revised their recommendations to a the median intra-service time of 25 minutes and the median work RVU of 1.71. To substantiate this recommendation, the RUC noted that the work of 75791 is very similar to that of 75790, though the intra-service time is slightly lower than the existing physician time of 34 minutes. Moreover, the existing physician work RVU of 75790 is slightly higher than the recommended work RVU, 1.84 versus 1.71, respectively. **Therefore, the RUC recommends a work RVU of 1.71 and an intra-service time of 25 minutes, with 15 minutes pre-service evaluation and 15 minutes immediate post-service time for CPT code 75791.**

1324

Work Neutrality

The specialty society provided data to the RUC showing that the new coding structure will account for an overall decrease in work relative values for this family of services to be redistributed in the Medicare conversion factor. Currently, 36145 and 75790 are reported together approximately 95% of the time accounting for roughly 250,000 combined reporting. The specialty society estimates that 36147 will be reported approximately 188,000 times and 36148 will be reported 62,000 times. 75791 will only be reported on rare occasions (i.e., less than 1,000 per year).

Practice Expense

The RUC agreed that moderate sedation is inherent in 36147 and 36148. The supplies, equipment and clinical staff time were edited to reflect that moderate sedation is inherent.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 36145		~~Introduction of needele or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)~~ *(For insertion of arteriovenous cannula, see 36810-36821)* (36145 has been deleted. To report see 36147, 36148)	XXX	N/A
Ø•36147	W1	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial acess, with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava) (If 36147 indicates the need for a therapeutic intervention requiring a second catheterization of the shunt, use 36148) (Do not report 36147 with 75791)	XXX	3.72
Ø •+36148	W2	additional access for therapeutic intervention (List separately in addition to code for primary procedure) (Use 36148 in conjunction with 36147)	ZZZ	1.00
D 75790		~~Angiography, arteriovenous shunt (eg, dialysis pateint), radiological supervision interpretation~~ (Code 75790 has been deleted. To report, use 36147, 75791)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•75791	W3	Angiography, arteriovenous shunt (dialysis fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation Do not report 75791 in conjunction with 36147) (For introduction of catheter, if necessary, see 36140, 36215-36217, 36245-36247) (Use 75791 only if radiological evaluation is performed through an already existing access into the shunt or from an access that is not a direct puncture of the shunt) (For radiological evaluation with needle/catheter introduction, AV dialysis shunt, complete procedure, use 36147)	XXX	1.71

1326

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36147 Tracking Number W1 Specialty Society Recommended RVU: **3.72**

Global Period: XXX RUC Recommended RVU: **3.72**

CPT Descriptor: Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old man with ESRD is referred for evaluation because of increased difficulty puncturing the AV shunt for dialysis. He has been on hemodialysis for 5 years, and this is his second AV shunt. He has an AV fistula in the left upper arm, and was most recently studied 10 months ago, at which time a 2cm stenosis of the arteriovenous anastomosis and immediate outflow was found and treated with balloon angioplasty.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 81%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 73%

Is moderate sedation inherent in your reference code (Office setting)? Yes
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:
-Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
-Estimate the range of devices that may be required and ensure all are available for use
-Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
-Check the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues
-Re-review applicable, available prior films
-Don radiation protection device

Description of Intra-Service Work:
- Position (or supervise) proper positioning of patient
- IV set up is checked and moderate sedation administered
- Local anesthesia is applied to the entry site and the arterivenous shunt is punctured and sheath placed

- Angiography is performed to include the entire length of the graft and all outflow veins to the level of the superior vena cava. Compression may be applied to allow visualization of the arterial anastamosis
- Technical personel are directed throughout
- Interpretation of the imaging of all views obtained
  Sheath and any neccesary catheters and wires are removed from the body
- Hemostasis is obtained by direct compression
- Review and interpret all images
- Dictate a report for the medical record

Description of Post-Service Work:
- Make a note in the patient record
- Discuss the outcome of the procedure with the patient and family and instructions are given
- Review, revise and sign final report

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Robert Zwolak, MD, David Han, MD, Matthew Sideman, MD				
Specialty(s):	ACR, SIR, SVS				
CPT Code:	36147				
Sample Size:	450	**Resp N:**	68	**Response:** 15.1 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	30.00	**50.00**	100.00	500.00
Survey RVW:	1.00	3.96	**4.70**	5.00	16.02
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36147	**Recommended Physician Work RVU: 3.72**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**33.00**	**-13.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
43260	000	5.95	**RUC Time**	16,802

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 30 **% of respondents:** 44.1 %

TIME ESTIMATES (Median)	CPT Code: 36147	Key Reference CPT Code: 36558	Source of Time RUC Time
Median Pre-Service Time	20.00	36.00	
Median Intra-Service Time	45.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	0.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**80.00**	**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	3.23	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.37	2.70
Urgency of medical decision making	3.20	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	2.90
Physical effort required	3.47	2.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	2.93
Outcome depends on the skill and judgment of physician	3.60	3.03
Estimated risk of malpractice suit with poor outcome	3.07	2.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.07	2.47
Intra-Service intensity/complexity	3.43	2.77
Post-Service intensity/complexity	3.00	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.*

ACR, SIR, and SVS convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 36558 with work value of 4.81. The median survey data for 36XX1 shows work value of 4.70 with 20 min pre, 45 min intra, and 15 min post.

The societies are recommending a work value of 3.85 (which falls just below the 25th percentile) and median physician time of 20 min pre, 45 min intra, and 15 min post. Code 36147 was previously coded using codes 36145 (Introduction f needle or intracatheter; arteriovenous shunt created for dialysis) with work value of 2.01 and 75790 (Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation) with work value of 1.84. The panel believes that the sum of 2.01 and 1.84 best reflects the work involved with code 36XX1. Moreover, the total time of the codes 36145 / 75790 equal 57 minutes, which compares favorably to the 80 minutes of median physician time of our surveys. CMS required us to survey 36147 as an XXX code, which makes it somewhat difficult to allocate respondents' time. When compared to the reference service, the panel recognizes that 36558 has 1.09 RVU post-operative care in the global period making the comparable value for 36558 3.72 RVU; however, survey respondents rated the intensity and complexity of 36147 greater than 36558, for all 11 measures, which, combined with our recommendation for a lower RVU as compared to the median RVU, is believed to account for the difference in 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) 36145, 75790

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology How often? Commonly

Specialty Interventional Radiology
How often? Commonly

Specialty Vascular Surgery How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1436454

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 36145 and 75790 in a one year period is estimated to be 1436454 (765384 for 36145 and 671070 for 75790).

Specialty Radiology Frequency 649421 Percentage 45.21 %

Specialty Interventional Radiology Frequency 160596 Percentage 11.18 %

Specialty Vascular Surgery Frequency 149391 Percentage 10.39 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 478,818 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2007 Medicare data estimates that codes 36145 and 75790 were billed approximately 478818 (255128 for 36145 and 223690 for 75790).

Specialty Radiology Frequency 216519 Percentage 45.21 %

Specialty Interventional Radiology Frequency 53556 Percentage 11.18 %

Specialty Vascular Surgery Frequency 49816 Percentage 10.40 %

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. 19103. Physician work involved for 36XX1 is more comparable to code 19103.

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: 36148 Tracking Number W2 Specialty Society Recommended RVU: **1.00**

Global Period: ZZZ RUC Recommended RVU: **1.00**

CPT Descriptor: Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with ESRD is referred for study of a dialysis access (either graft or fistula) that is not performing well. The patient is seen in an angiographic laboratory. The AV shunt is punctured under local anesthesia and a diagnostic study of the AV shunt is performed (coded as 36XX1). The diagnostic study demonstrates a significant stenosis just below the puncture site that requires balloon angioplasty. A second puncture is required to reach the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 82%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 74%

Is moderate sedation inherent in your reference code (Office setting)? Yes
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work:

Description of Intra-Service Work:
- Local anesthesia is applied to the second entry site and the arterivenous shunt is punctured and sheath placed
Moderate sedation is monitored
- Required interventions are performed (reported separately)
- Sheath and any neccesary catheters and wires are removed from the body
Hemostasis is obtained by direct compression
Dictate a report for the medical record

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD, Robert Zwolak, MD, David Han, MD, Mathew Sideman, MD				
Specialty(s):	ACR, SIR, SVS				
CPT Code:	36148				
Sample Size:	450	**Resp N:**	45	**Response:** 10.0 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	20.00	**50.00**	100.00	500.00
Survey RVW:	1.00	2.37	**4.13**	5.00	10.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	5.00	15.00	**30.00**	45.00	90.00

Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	____	99291x	99292x			
Other Hospital time/visit(s):	____	99231x	99232x	99233x		
Discharge Day Mgmt:	____	99238x	99239x			
Office time/visit(s):	____	99211x	12x	13x	14x	15x
Prolonged Services:	____	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

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36148	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**33.00**	**-33.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? 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
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	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 26.6 %

TIME ESTIMATES (Median)	**CPT Code: 36148**	**Key Reference CPT Code: 36558**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	36.00	
Median Intra-Service Time	15.00	30.00	
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	19.00	
Median Office Visit Time	0.0	16.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**15.00**	**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	3.08	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.92	2.58
Urgency of medical decision making	3.00	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	2.83
Physical effort required	3.25	2.92

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.83
Outcome depends on the skill and judgment of physician	3.50	2.92
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	2.82	2.67
Intra-Service intensity/complexity	3.08	2.83
Post-Service intensity/complexity	2.83	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 Valu Recommendations for the appropriate formula and format.*

ACR, SIR, and SVS convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 36558 with work value of 4.81. Although the

survey median work value is 4.13, the panel recommends a work value of 1.00 as code 36148 was previously coded using code 36145 with a work value of 2.01 subject to modifier -51. A value of 1.00 maintains the current work value.

Another example is 36620 (Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate rocedure); percutaneous), which is modifier -51 exempt. It has a work value of 1.15 RVU with 7 minutes pre, 10 minutes intra, and 5 minutes post. While we believe the work of cannulating a poorly functioning dialysis graft is more difficult than placement of a routine arterial line, we believe that this code represents a reasonable comparison since as a ZZZ code, 36148 is also modifier -51 exempt. Since the respondents may not have understood the complexities of add on codes and modifier -51 exempt codes, we believe that 15 minutes of intra-service time best reflects the time involved for 36148. Therefore, the panel recommends a work RVU of 1.00 and an intra-service time of 15 minutes with no pre 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)

Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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.

4.		Work value	Pre	Intra	Post	Total	Global
5.	36148	1.00		15		15	ZZZ
6.	36147	3.85	15	45	15	75	XXX
7.	G0393	6.03					000
8.	75978	0.54				12	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 36145

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.

ecialty Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Vascular Surgery How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 765384
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 36145 in a one year period is estimated to be 765384.

Specialty Radiology Frequency 352995 Percentage 46.11 %

Specialty Interventional Radiology Frequency 88708 Percentage 11.58 %

Specialty Vascular Surgery Frequency 76385 Percentage 9.97 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 255,128 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2007 Medicare data estimates that CPT code 36145 was billed approximately 255128 times.

Specialty Radiology Frequency 117687 Percentage 46.12 %

Specialty Interventional Radiology Frequency 29588 Percentage 11.59 %

Specialty Vascular Surgery Frequency 25485 Percentage 9.98 %

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. 36620. Physician work for code 36XX2 is more comparable to code 36620.

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:75791 Tracking Number W3 Specialty Society Recommended RVU: **1.71**

Global Period: XXX RUC Recommended RVU: **1.71**

CPT Descriptor: Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injection(s) of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with ESRD is found to have poor flows during dialysis, with clotting of the needle, such that dialysis cannot be completed. The patient is sent to the angiographic suite with needles in place for a diagnostic study to evaluate the AV shunt.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 71%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 55%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
-Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
-Re-review applicable, available prior films
-Check the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safty issues
-Re-review applicable, available prior films
- Don radiation protection device

Description of Intra-Service Work:
Angiography is performed to include the entire length of the graft and all outflow veins to the level of the superior vena cava. Compression may be applied to allow visualization of the arterial anastamosis
- Technical personel are directed throughout
- Interpretation of the imaging of all views obtained
- Review and interpret all images

- Dictate a report for the medical record

Description of Post-Service Work:
- Make a note in the patient record
- Discusse the outcome of the procedure with the patient and family and instructions are given
- Review, revise and sign final report

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Gerald Niedzwiecki, MD,Robert Vogelzang, MD, Robert Zwolak, MD, David Han, MD, Mathew Sideman, MD				
Specialty(s):	ACR, SIR, SVS				
CPT Code:	75791				
Sample Size:	450	**Resp N:**	31	**Response:** 6.8 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	10.00	**25.00**	58.00	500.00
Survey RVW:	0.70	1.00	**1.84**	2.84	6.75
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	18.00	**30.00**	45.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	75791	**Recommended Physician Work RVU: 1.71**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**33.00**	**-18.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**5.00**	**-5.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
49424	000	0.76	**RUC Time**

CPT Descriptor Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (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	Work RVU	Time Source	Most Recent Medicare Utilization
93312	XXX	2.20	**RUC Time**	211,899

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 22.5 %

TIME ESTIMATES (Median)

	CPT Code: 75791	**Key Reference CPT Code: 49424**	**Source of Time**
Median Pre-Service Time	15.00	12.00	**RUC Time**
Median Intra-Service Time	25.00	15.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**55.00**	**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	2.86	2.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.29
Urgency of medical decision making	2.29	2.14

Technical Skill/Physical Effort (Mean)

Technical skill required	2.14	1.86
Physical effort required	1.86	1.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	1.86
Outcome depends on the skill and judgment of physician	2.43	2.00
stimated risk of malpractice suit with poor outcome	2.14	1.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.14	1.71
Intra-Service intensity/complexity	2.43	1.71
Post-Service intensity/complexity	1.86	1.86

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an RVPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ACR, SIR, and SVS convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 49424 with work value of 0.76. The panel recommends median work value of 1.84 with the median percentile physician time of 15 min pre, 30 min intra, and 15

min post. Our experts acknowledge that 75791 is more complex than the reference code. This is due to the increased complexity and variability of the vasculature compared to assessing healing of an abscess cavity. 75791 requires a greater number of views, patient positions and graft compression to visualize the length the fistula, arterial inflow and venous outflow.

Additionally 75791 can be considered the sum of 75820 (Venography, extremity, unilateral, radiological supervision and interpretation) 0.7 RVU + 75827 (Venography, caval, superior, with serialography, radiological supervision and interpretation) 1.14 RVU, which is our median value of 1.84 RVU. While the codes are not RUC valued, the Harvard times of 14 min for 75820 plus 22 min for 75827 (total 36 min) compare favorably with the survey times for 75791.

SERVICES REPORTED WITH MULTIPLE 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) 75790

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Vascular Surgery How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 296496
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. The overall number of services for 75790 in a one year period is estimate to be 296496.

Specialty Radiology Frequency 13099 Percentage 4.41 %

Specialty Interventional Radiology Frequency 31754 Percentage 10.70 %

Specialty Vascular Surgery Frequency 32229 Percentage 10.86 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,690 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The Medicare data estimates that code 75790 was billed approximately 98,832 times.

Specialty Radiology Frequency 98832 Percentage 44.18 %

Specialty Interventional Radiology Frequency 23968 Percentage 10.71 %

Specialty Vascular Surgery Frequency 24331 Percentage 10.87 %

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. 75662

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor: Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)

Sample Size: N/A Response Rate: (%): N/A Global Period: XXX

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:

The SIR, ACR, and SVS convened a group of radiologists and vascular surgeons from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Follow up phone calls and prescriptions

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

- Conduct phone calls/ call in prescriptions

Please see corresponding PERC spreadsheet for additional detail.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
Global Period: XXX

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:

The SIR, ACR, and SVS convened a group of radiologists and vascular surgeons from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions
- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position the patient/monitor patient/set up IV
- Sedate/apply anesthesia
- Monitor the patient during the procedure
- Assist MD in the procedure
- Assist MD in fluoroscopy and acquisition of imaging data
- Monitor pt. after service: check tubes, monitors, puncture sites
- Clean room/equipment by physician staff
- Check dressings and wound/home care instructions/coordinate office visits/prescriptions
- Pre-procedure Doppler check in addition to initial vitals
- Post procedure Doppler check in addition to initial vitals
- Post procedure film development and hanging of films

Post-Service Clinical Labor Activities:

- Conduct phone calls/ call in prescription

Please see corresponding PERC spreadsheet for additional detail.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Period
Non-Facility Direct Inputs

CPT Long Descriptor: Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)

Sample Size: NA Response Rate: (%): NA Global Period: ZZZ

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:

The SIR, ACR, and SVS convened a group of radiologists and vascular surgeons from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

e-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

- Prepare additional supplies
- Sedate/apply anesthesia
- Monitor the patient during the procedure
- Assist MD in the procedure
- Clean room/equipment by physician staff

Post-Service Clinical Labor Activities:

Please see corresponding PERC spreadsheet for additional detail.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injection(s) of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation

Sample Size: NA_ Response Rate: (%): NA Global Period: XXX

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:

The SIR, ACR, and SVS convened a group of radiologists and vascular surgeons from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

- Prepare room, equipment, supplies
- Prepare and position the patient/monitor patient/set up IV
- Sedate/apply anesthesia
- Monitor the patient during the procedure
- Assist MD in fluoroscopy and image acquisition
- Assist MD in the procedure
- Monitor pt. after service: check tubes, monitors, drains
- Clean room/equipment by physician staff
- Post procedure film development and hanging of films

Post-Service Clinical Labor Activities:

Please see corresponding PERC spreadsheet for additional detail.

	A	B	C	D	E	F	G	H	
1				36147		36148		75791	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)		Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)		Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injection(s) of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX	XXX	ZZZ	ZZZ	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			190.0	6.0	32.0	0.0	66.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			15.0	3.0	0.0	0.0	6.0	0.0
7		L037D	RN/LPN/MTA	9.0	3.0				
8		L041B	RT	6.0				6.0	
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			44.0	0.0	32.0	0.0	60.0	0.0
10		L037D	RN/LPN/MTA	21.0					
11		L051A	RN	44.0		17.0			
12		L041B	RT	54.0		4.0		37.0	
13		L041B	RT (scrub)	34.0		11.0		23.0	
14	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	3.0	0.0	0.0	0.0	0.0
15		L037D	RN/LPN/MTA	3.0	3.0				
16	PRE-SERVICE								
17	**Start: Following visit when decision for surgery or procedure made**								
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3					
19	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3					
20	Schedule space and equipment in facility								
21	Provide pre-service education/obtain consent								
22	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3				
23	Other Clinical Activity (please specify)								
24	Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD	L041B	RT	6				6	
25	**End: When patient enters office/facility for surgery/procedure**								
26	SERVICE PERIOD								
27	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
28	Review charts	L037D	RN/LPN/MTA	2					
29	Greet patient and provide gowning	L037D	RN/LPN/MTA	3					
30	Obtain vital signs	L037D	RN/LPN/MTA	5					
31	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5					
32	Prepare room, equipment, supplies	L041B	RT	7		3		3	
33	Setup scope (non facility setting only)								
34	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	5				3	
35	Sedate/apply anesthesia	L051A	RN			2			

	A	B	C	D	E	F	G	H	I
1				36147		36148		75791	
2	**Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation**	CMS	Staff	**Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**		**Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**		**Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injection(s) of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
36	**Intra-service**								
37	Monitor the patient during the procedure	L051A	RN	45		15			
38	Assist MD with fluoroscopy and image acquisition	L041B	RT	34				23	
39	Assist MD in the procedure	L041B	RT (scrub)	34		11		23	
40	**Post-Service**								
41	Monitor pt. following service/check tubes, monitors, puncture site	L051A	RN	18					
42	Clean room/equipment by physician staff	L041B	RT	3		1		3	
43	Clean Scope								
44	Clean Surgical Instrument Package								
45	Complete diagnostic forms, lab & X-ray requisitions								
46	Review/read X-ray, lab, and pathology reports								
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3					
48	Discharge day management								
49	Other Clinical Activity (please specify)								
50	Pre-procedure doppler check in addition to initial vitals	L037D	RN/LPN/MTA	3					
51	Post procedure film development and hanging of films	L041B	RT	5				5	
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	3	3				
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	1				1	
59	gown, surgical, sterile	SB028	item	2				2	
60	gloves, sterile	SB024	pair	2				2	
61	mask, surgical, with face shield	SB034	item	2				2	
62	cap, surgical	SB001	item	2				2	
63	shoe covers, surgical	SB039	pair	2				2	
64	tray, shave prep	SA067	tray	1					
65	drape, sterile, femoral	SB009	item	1				1	
66	drape-towel, sterile 18inx26in	SB019	item	4				4	
67	underpad 2ftx3ft (Chux)	SB044	item	2				2	
68	povidone soln (Betadine)	SJ041	ml	60				60	
69	applicator, sponge-tipped	SG009	item	4				4	
70	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10			
71	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2				2	

1355

	A	B	C	D	E	F	G	H	
1				36147		36148		75791	
2	**Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**		**Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**		**Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injection(s) of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
72	heparin 1,000 units-ml inj	SH039	ml	5					
73	sodium chloride 0.9% flush syringe	SH065	item	1				1	
74	closed flush system, angiography	SC010	item	1				1	
75	catheter, angiographic, pig-tail	SC008	item	1					
76	blade, surgical (Bard-Parker)	SF007	item	1					
77	kit, AccuStick II Introducer System with RO Marker (includes; 21G Needle, 0.018" Wire, RO Sheath Marker, 4Fr Dilator, 6Fr Sheath, 0.038" Wire)		kit	1		1			
78	guidewire	SD088	item	1		1			
79	steri-strip (6 strip uou)	SG074	item	1		1			
80	gauze, sterile 4in x 4in	SG055	item	2		2			
81	tape, surgical paper 1in (Micropore)	SG079	item	6		6			
82	Conray Inj (iothalamate 43%)	SH026	ml	40				40	
83	drape, sterile, c-arm, fluoro	SB008	item	1				1	
84	x-ray ID card (flashcard)	SK093	item	1				1	
85	x-ray envelope	SK091	item	1				1	
86	film, x-ray 14inx17in	SK034	item	4				4	
87	x-ray developer solution	SK089	oz	1				1	
88	x-ray fixer solution	SK092	oz	1				1	
89	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1				1	
90	computer media, dvd	SK013	item	1				1	
91	pack, conscious sedation	SA044	item	1					
92	Equipment	CMS Code							
93	Equipment (post procedure observation only)								
94	exam lamp	EQ168		X					
95	stretcher chair	EF019		X					
96									
97	Equipment (other)								
98	angiographic room	EL011		X		X		X	
99	infusion pump	EQ032		X					
100	film alternator	ER029		X				X	
101	film printer, laser	ED032		X				X	
102	cardio-respiratory monitor	EQ011		X					
103	pulse oximeter	EQ211		X					
104	oxygen tank	EQ192		X					

1356

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from the Five Year Review

April 2009

Perforator Vein Ligation

CPT code 37760 *Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open* was identified by the Five Year Review Identification Workgroup as potentially misvalued through its site of service anomaly screen in September 2007. The specialty societies agreed that this code was inappropriately being used to report a less extensive perforating vein operation stems therefore, the specialty society requested and the RUC agreed that the service be referred to CPT to clarify the descriptor of the existing code and create a new code to report a less extensive perforator vein ligation. To address this concern the CPT Editorial Panel editorially revised 37760 and established a new code to report 37761 which is a subfascial ligation of the perforator vein through a direct open surgical approach.

1358

The RUC reviewed the survey data for 37761 and agreed with the specialty societies' recommendation for an additional 7 minutes of positioning time based on the need to get the patient in a position where the surgeon can target the lower extremity. The RUC compared the surveyed code to its reference code, 37500 *Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)* (Work RVU=11.54). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 60 minutes and 90 minutes, respectively. In addition, the RUC compared the surveyed codes to another reference code, MPC code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (Work RVU=10.50). The RUC noted that the surveyed code has less intra-service time as compared to the MPC reference code, 60 minutes and 90 minutes, respectively. Further, the RUC noted that the surveyed code required less technical skill, physical and mental effort and judgment to perform than the key reference code. Therefore, based on these comparisons, the RUC agreed with the specialty societies' recommended 9.00 work RVUs, the survey median, for this procedure. **The RUC recommends 9.00 Work RVUs for 37761.**

CPT Recommendation:
During the presentation to the RUC, the specialty societies indicated that ultrasound guidance would be included in the work for this procedure. Therefore, the RUC recommends that a parenthetical be added following the descriptor for 37761 that indicates that ultrasound guidance should not be reported separately.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies 090 day global standards.

Work Neutrality:
The RUC recommendations for this issue will result in a work savings that should be redistributed in the Medicare conversion factor.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 37760		Ligation of perforator veins, subfascial, radical (Linton type), including ~~with or without~~ skin graft when performed, open, one leg	090	10.69 (No Change)
●37761	X1	Ligation of perforator vein(s), subfascial, open, includes ultrasound guidance, when performed; one leg (For bilateral procedure, report 37761 with modifier 50) (Do not report 37760-37761 with 76998, 76937, 76942, 93971) (For endoscopic ligation of subfascial perforator veins use 37500)	090	9.00
Radiology Other Procedures				
76998		Ultrasonic guidance, intraoperative (Do not report 76998 in conjunction with 47370-47382, 36475-36479, 37760-37761)	XXX	1.20 (No Change)

1359

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37761 Tracking Number X1 Specialty Society Recommended RVU: **9.00**

Global Period: 090 RUC Recommended RVU: **9.00**

CPT Descriptor: Ligation of perforator vein(s), subfascial, open, one leg

(For bilateral procedure, report 37761 with modifier 50)
(Do not report 37760-37761 with 76998, 93971)
(For endoscopic ligation of subfascial perforator veins use 37500)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman presents with her third medial left leg ulcer. It measures 3x3 cm and is deep and painful. She has palpable pedal pulses and pigmentary scarring in the gaiter distribution of the extremity. A left greater saphenous vein ligation and stripping was performed a year earlier and improved but did not completely relieve her symptoms. Duplex scanning reveals large incompetent perforating veins just cephalad to the ulcer. Open ligation of the perforators is undertaken.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Percent of survey respondents who stated they perform the procedure; In the hospital 78% , In the ASC 7%, In the office 16%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 83% , Kept overnight (less than 24 hours) 11% , Admitted (more than 24 hours) 6%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 25%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 14%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review all relevant office notes, H&P, noninvasive vascular lab studies
- Update H&P (required by JCAHO)
- Review operative plan and informed consent with patient and family
- Discuss patient comorbidities and surgical approach with Anesthesiologist
- Change into OR scrubs
  Perform a limited venous duplex scan to mark the perforating vein(s) on the skin with indelible marker
  Supervise patient positioning, skin prep, and draping
- Wait for anesthetic to become effective

Description of Intra-Service Work:

- Incise skin of lower extremity 1 cm from the marked perforator taking care to avoid chronically scarred regions

- Dissect the subcutaneous tissue using retraction to expose the fascia and the perforating vein
- Incise the fascia taking care not to injure the vein
- Isolate the vein
- Place a ligature around the vein and ligate the vein
- Close the fascia with interrupted sutures
- Repeat above steps for each vein to be treated
- Irrigate wound(s) copiously with sterile saline
- Use electrocautery or suture ligation to achieve final hemostasis at all sites
- Close subcutaneous tissue in multiple layers
- Close skin

Description of Post-Service Work:

- Apply dressings
- Transfer patient to stretcher, elevate limb on pillows, accompany patient to recovery area
- Write orders
- Dictate operative note
- Communicate with family, referring and consulting physicians
- Participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia
- Discuss results of procedure with the patient once he/she is fully awake
- When stable, the patient is transferred to the ambulatory care area
- Write Discharge instructionsincluding activity, warnings, schedule office visit, wound checks, suture removal, etc.
- All related outpatient office visits until completion of the global period

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009					
Presenter(s):	Gary Seabrook MD FACS, Christopher Senkowski MD FACS, Matthew Sideman MD FACS, Robert Zwolak MD FACS					
pecialty(s):	SVS, ACS					
CPT Code:	37761					
Sample Size:	125	**Resp N:**	36	**Response:** 28.8 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**3.00**	5.00	30.00
Survey RVW:		3.00	8.00	**9.00**	10.50	14.00
Pre-Service Evaluation Time:				**45.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		20.00	45.00	**60.00**	65.00	120.00
Immediate Post Service-Time:	**25.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**				
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	37761	**Recommended Physician Work RVU: 9.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		
Immediate Post Service-Time:	**25.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
scharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**		
fice time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
37500	090	11.54	RUC Time

CPT Descriptor Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36832	090	10.50	RUC Time	14,190

CPT Descriptor 1 Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44950	090	10.52	RUC Time	5,801

CPT Descriptor 2 Appendecomy

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 36.1 %

TIME ESTIMATES (Median)	CPT Code: 37761	Key Reference CPT Code: 37500	Source of Time RUC Time
Median Pre-Service Time	58.00	60.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	25.00	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	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**224.00**	**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	3.23	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.46
Urgency of medical decision making	2.54	2.54
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.62	3.85
Physical effort required	3.15	3.23
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.38	3.46
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.38	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.69	3.77
Intra-Service intensity/complexity	3.31	3.54
Post-Service intensity/complexity	3.00	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.*

Introduction: This new open perforator vein ligation code is being created as a product of the Five-year Review Workgroup. CPT code 37760 (Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open) was identified by the screen of rapidly growing services in the Medicare database. SVS suggested that most of the surgeons performing Ligation of perforator veins were not actually doing the old radical Linton type operation, but a less

invasive variation. The society therefore requested creation of 3776X, and we suspect that when this code is introduced the frequency of reporting 37760 will drop almost to nothing.

IWPUT: At the median survey recommended RVW of 9.00, and with the recommended time and visit pattern, the new service has an IWPUT of 0.074, fully consistent with the key reference service (0.073) as well as other recently RUC-valued vein excision operations.

Pre-time considerations: We are request 7 minutes of additional pre-service positioning time based on need to get the target lower extremity to be in perfect position on the table. Additional time is also required at this point to locate the "leg holder" staff person, get him/her in the room, set up with sterile gloves and/or sterile towel to appropriate hold up the leg for a full circumferential lower extremity sterile prep.

Clinical Comparison with Key Reference: The key reference service chosen by 36% of survey respondents is 37500 Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS). In essence, new code 3776X accomplishes the same clinical endpoint as 37500, but through a direct open surgical approach.

Work Comparison with Key Reference: The primary difference between 37500 SEPS and new code 3776X lies in the intra-service time. New code 3776X requires 30 minutes LESS intra-time than key reference 37500 (60 min compared to 90). Otherwise, the two services have essentially the same pre-time (new code 58 min, key reference 60 min). The new service has 5 minutes LESS immediate post-service time (25 min vs. 30). Both codes are performed in the typical patient as hospital same-day discharge outpatients, and both have therefore 0.5 discharge day at 19 minutes each. The two codes have the same office visit pattern, at 62 minutes each. Intensity and complexity measures of the two codes are similar, but if anything the new service has very slightly lower I&C grades across the board.

Given these similarities, it is reasonable to estimate a work value for the new code based on the RVW of the key reference. The math entails subtracting 30 minutes of intra-time at the typical IWPUT for vein surgery of 0.070. The RVW of 37500 is 11.54. 30 minutes of intra-time at 0.070 is 2.1 RVUs. An estimated RVW of new service is 11.54 minus 2.1 = 9.44. This compares favorably with our recommended median survey value of 9.00.

Work Comparison with MPC Vascular Reference code 36832 Hemoaccess Revision: 36832 is an open revision of arteriovenous hemodialysis access that was carried through the RUC process in 1998. 36832 has an RVW of 10.50 with 90 minutes of intra-time, one office visit and 191 minutes of total time. New service 3776X is recommended at an RVW of 9.00, and it has 60 minutes of intra-time, three office visits, and 224 minutes of total time. IWPUT of 36832 is 0.090. A downward adjustment from 36832 to account for 30 minutes less intra-time can be established as 30 x 0.090 = 2.70. An upward adjustment for two more office visits in 3776X compared to 36832 can be calculated as (0.92+0.45=1.37). Thus, an estimate for new code 3776X based on 36832 is 10.50 - 2.70 + 1.37 = 9.17. This is again very close to our median survey recommended RVU of 9.00.

Work Comparison with MPC General Surgery Reference code 44950 Appendectomy: 44950 is open appendectomy, a service that was evaluated by the RUC during the second 5-year review. 44950 has an RVW of 10.52, an intra-service time of 60 minutes (same as the new code), and the same office visit pattern. In order to estimate a value for the new code based on 44950 one must start with 10.52, subtract two inpatient hospital days (1.52), subtract 0.5 discharge day visit (0.64), and add back one office visit (99212 @ 0.45). This value is 10.52-1.52-0.64 + 0.45 = 8.81. This is again quite close to the recommended RVW for the new service of 9.00, desp the lack of clinical similarity between the procedures.

Summary: Based on all the above data and comparisons, we believe the median survey RVW of 9.00 is appropriate for this new 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. New code 3776X may be co-reported in some patients with one of a variety of treatments for the greater saphenous vein or symptomatic varicose veins. These codes include: 37722 (ligation, division & stripping of greater saphenous vein (RVW 8.08), 37718 (ligation, division & stripping of short saphenous vein (RVW 7.05); stab phlebectomy (37765, 37766; RVWs 7.63 / 9.58); radiofrequency ablation of the greater saphenous vein (36475 @ 6.72), or laser ablation of the greater saphenous vein (36478 @ 6.72). In each case, the 50% multiple procedure payment reduction would be in effect for the second code.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37760, 37799 unlisted vascular procedure and 35585

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 GS	How often? Sometimes
Specialty VS	How often? Sometimes
Specialty TS	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 3600
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate twice the Medicare volume of 37760. There is no other source of data on which to make this determination

Specialty GS	Frequency 1368	Percentage 38.00 %
Specialty VS	Frequency 1152	Percentage 32.00 %
Specialty TS	Frequency 540	Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,800 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. 1725 from 37760, 50 from 37799 unlisted vascular procedure and 25 from 35585

Specialty GS	Frequency 684	Percentage 38.00 %
Specialty VS	Frequency 576	Percentage 32.00 %
Specialty TS	Frequency 279	Percentage 15.50 %

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
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

X1	37761	Ligation of perforator veins, subfascial, open, one leg

Sample Size: N/A

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 committee of vascular surgeons and general surgeons agree that this procedure would not be performed in an office setting and this would not be an emergency procedure.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the facility to schedule space and equipment needed and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. nical staff will provide and review educational materials and information including instructions on changes to dications prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy with the PCP prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management and office visit related activities are performed.

	A	B	C	D	E
1				X1	
2	**Meeting Date: April 2009**			37761	
3	**AMA/Specialty Society RVS Update Committee Recommendation**			Ligation of perforator veins, subfascial, open, one leg	
4	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**165**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**99**
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**				
39	Discharge day mgmt 99238 –12 min, 99239 –15 min	**L037D**	RN/LPN/MTA		**6**
41	**End: Patient leaves office**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
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		
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**0**	**99**
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**	**Code**	**Unit**		
56	pack, minimum multi-specialty visit	**SA048**	**pack**		**3**
57	pack, post-op incision care (suture)	**SA054**	**pack**		**1**
58					
59	**Equipment**	**Code**			
60	table, power	**EF031**			**99**
61	light, exam	**EQ168**			**99**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Rectal Tumor Excision

CPT code 45170, *Excision of tumor, transanal approach* was identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. Code 45172 was also identified in the High IWPUT screen and discussed by the RUC at its February 2008 meeting. The RUC recommended that the service be referred to CPT because the current descriptor allowed reporting of the code to a bi-modal distribution of patients. In October 2008, the CPT Editorial Panel deleted 45170 (work RVU = 12.48) and replaced it with two new Category I codes to provide greater granularity, 45171, *Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)* and 45172, *Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness).*

1372

45171
The specialty society presented the survey data from 92 general and colorectal surgeons. The RUC reviewed the intra-service physician time and noted that the median time of 45 minutes was appropriate. The specialty indicated that this service would typically be provided on an outpatient basis. The RUC agreed with the specialty society that the pre-service time package should be package #3, straightforward patient/difficult procedure, as this time most accurately reflects the work performed. However, the RUC did not agree with the specialty that 20 minutes of positioning time was correct. Survey respondents indicated that 15 minutes were necessary. Therefore, the RUC adjusted the pre-service positioning time from the 3 minutes within package #3 to 15 minutes, rather than the 20 minutes recommended by the specialty. The RUC then reviewed the survey RVU and agreed with the specialty society that the survey 25th percentile work recommendation of 8.00 was appropriate. The RUC considered the surveyed code in comparison to the key reference service, 45190, *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU = 10.29). The RUC noted that despite similar intensity and complexity measurements between the surveyed code and the key reference code, the reference code requires 15 additional minutes of intra-service time (60

minutes and 45 minutes, respectively). Based on this comparison, the RUC agreed that the survey 25th percentile work RVU of 8.00 was appropriate. **The RUC recommends the survey 25th percentile RVU of 8.00 for 45171.**

45172

The specialty society presented the survey data from 92 general and colorectal surgeons. The RUC reviewed the intra-service physician time and noted that the median time of 75 minutes was appropriate. The RUC agreed with the specialty society that the pre-service time package should be package #4, difficult patient/difficult procedure, as this time most accurately reflects the work performed. However, the RUC did not agree with the specialty that 20 minutes of positioning time was correct. Survey respondents indicated that 15 were necessary. Therefore, the RUC adjusted the pre-service positioning time from the 3 minutes within package #4 to 15 minutes, rather than the 20 minutes recommended by the specialty. The RUC then reviewed the survey RVU and agreed with the specialty society that the survey median work RVU of 12.00 was appropriate. The RUC considered the surveyed code in comparison to the key reference service, 45190, *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU = 10.29). The RUC noted that the key reference service requires 15 fewer minutes of intra-service time (60 minutes and 75 minutes, respectively). Code 45172 also includes a full 99238 discharge day management procedure as well as a 99231 hospital visit within its global period, whereas the reference code does not. The RUC agreed that 45172 would typically require an inpatient stay. Lastly, the RUC noted that survey respondents indicated 45172 requires greater mental effort and judgment as well as greater technical skill and physical effort than the reference code. In light of these differences, the RUC agreed that the median work RVU of 12.00 was appropriate. **The RUC recommends the survey median work RVU of 12.00 for 45172.**

1373

Practice Expense

The RUC recommended the standard 90 day global practice expense inputs.

Work Neutrality

The specialty society provided data to the RUC showing that the new coding structure will account for an overall decrease in work relative values for this family of services to be redistributed in the Medicare conversion factor. 45170 was reported 6,536 in 2007, accounting for 81,569 work RVUs. The specialty society estimates that 45171 will be reported approximately 5,000 times (5,000 x 8.00 = 40,000 work RVUs) and 45172 will be reported 2,000 times (2,000 x 12.00 = 24,000 work RVUs), which results in a reduction of 17,569 work RVUs (81,569 – (40,000 + 24,000) = 17,569).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 45170		~~*Excision of rectal tumor, transanal approach*~~	090	N/A
●45171	G1	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	8.00
●45172	G2	including muscularis propria (ie, full thickness) (For destruction of rectal tumor, transanal approach see 45190)	090	12.00
45190		Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach (For excision of rectal tumor, transanal approach, see 45171-451X 2)	090	10.29 (No Change)

1374

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:45171 Tracking Number G1 Specialty Society Recommended RVU: **8.00**

Global Period: 090 RUC Recommended RVU: **8.00**

CPT Descriptor: Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male presents with rectal bleeding. Clinical and diagnostic studies confirm a small 2.5 cm benign tumor of the posterior rectal wall with the lower margin 3 to 4 cm from the anal verge. He undergoes a transanal partial thickness excision of the tumor

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Percent of survey respondents who stated they perform the procedure; In the hospital 87% , In the ASC 13%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 60% , Kept overnight (less than 24 hours) 34% , Admitted (more than 24 hours) 6%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 93%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Confirm pre-operative enemas have been carried out. Review pre-operative work-up and labs. Review prior diagnostic studies. Reexamine patient to make sure that physical findings have not changed and update H&P. Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient/family. Obtain informed consent. Change into scrub clothes. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Assist with patient positioning (typically prone jackknife or dorsal lithotomy) and prepping/draping as needed. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A retractor system is utilized to evert the anal canal. A large anal retractor or rectal speculum is placed and a local anesthetic agent with epinephrine is injected into the submucosal plane of the lesion. Stay sutures are placed 1 cm proximal and 1 cm distal to the lesion. A 1 cm margin is outlined around the entire lesion. A local anesthetic/ns is injected into the submucosal plane under the lesion, in order to elevate the lesion off of the underlying muscular layer. An energy source (eg, electric cautery, harmonic scalpel) is utilized to excise the entir tumor. This is performed circumferentially around the lesion along the margin. The lesion is removed and sent pathology. Hemostasis is obtained and the defect is closed.

Description of Post-Service Work: Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note. Monitor patient stabilization in the recovery room. After patient is awake,

discuss surgery outcome with patient. Examine patient to assess for the development of complications (eg, perforation, bleeding). Dictate operative report (copy PCP and/or referring physician) and complete medical record documentation. Correctly assign CPT codes including Physicians Quality and Reporting Initiative (PQRI) add-on codes where appropriate. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment ith the patient, family and other healthcare professionals, including home restrictions, especially diet, activity, bathing. Reconcile medications and write orders for post-discharge medication. Complete all appropriate medical records, including discharge summary and discharge instructions, and insurance forms. A diagnostic sigmoidoscopy will be performed at one or more office visits to assess wound healing. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Guy Orangio, MD, FACS; Christopher Senkowski, MD, FACS				
Specialty(s):	colon and rectal surgery; general surgery				
CPT Code:	45171				
Sample Size:	300	**Resp N:**	92	**Response:** 30.6 %	
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:	5.31	8.00	**10.29**	11.00	20.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	30.00	**45.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**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

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	45171	**Recommended Physician Work RVU: 8.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
45190	090	10.29	**RUC Time**

CPT Descriptor Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal 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	Work RVU	Time Source	Most Recent Medicare Utilization
46262	090	7.80	**RUC Time**	249

CPT Descriptor 1 Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 44 **% of respondents:** 47.8 %

TIME ESTIMATES (Median)	CPT Code: 45171	Key Reference CPT Code: 45190	Source of Time RUC Time
Median Pre-Service Time	63.00	80.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**209.00**	**266.00**	
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	3.21	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.21
Urgency of medical decision making	2.91	3.08

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.52
Physical effort required	3.58	3.26

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.09	3.00
Outcome depends on the skill and judgment of physician	3.84	3.60
Estimated risk of malpractice suit with poor outcome	3.19	3.05

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.16	3.05
Intra-Service intensity/complexity	3.40	3.21
Post-Service intensity/complexity	2.67	2.60

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.*

Current code 45170 (*Excision of rectal tumor, transanal approach*) will be deleted in 2010 and replaced by two new codes (G1 and G2). Code 45170 was reviewed twice by the RUC, resulting in survey data that indicated the typical patient stayed in the hospital for one or more nights. The code was selected for review by the RUC 5YR ID Workgroup screen for site of service anomalies. During review of the survey data for this code, the RUC determined, and the surveying specialties agreed, that code 45170 represented a bimodal distribution of patients and

that the code should be reviewed by CPT. The ASCRS and ACS presented a CCP for deletion of code 45170 and creation of two new codes (G1 and G2) that differentiated depth of excision for rectal tumors.

Pre-Time: With respect to the pre-service time, we recommend package 3 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to position the patient prone jackknife or in dorsal lithotomy.
- Scrub/Dress/Wait: no change

G1 Recommendation: The consensus committee recommends the survey 25th percentile RVW of 8.00. This value is 33% less than the current RVW for 45170. This RVW is less than the key reference code 45190 (RVW=10.29) which has more intra-operative time. The RVW of 8.00 is also similar to MPC code 46262 (RVW=7.80), which has the same intra-op time, but slightly less post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 45170

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 colon and rectal surgerey How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. specialty extrapolation from 2006 Medicare utilization

Specialty colon and rectal surgery Frequency 4500 Percentage 60.00 %

Specialty general surgery Frequency 3000 Percentage 40.00 %

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 estimate based on 2006 Medicare utilization of 45170

Specialty colon and rectal surgery Frequency 3000 Percentage 60.00 %

Specialty general surgery Frequency 2000 Percentage 40.00 %

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. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:45172 Tracking Number G2 Specialty Society Recommended RVU: **12.00**

Global Period: 090 RUC Recommended RVU: **12.00**

CPT Descriptor: Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old male presents with rectal bleeding and watery diarrhea. Clinical and diagnostic studies confirm a large tumor of the posterior rectal wall with the lower margin 4 cm from the anal verge. He undergoes a transanal full thickness excision of the tumor.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Percent of survey respondents who stated they perform the procedure; In the hospital 99% , In the ASC 1%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 9% , Kept overnight (less than 24 hours) 40% , Admitted (more than 24 hours) 52%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 58%

, moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Confirm pre-operative enemas have been carried out. Review pre-operative work-up and labs. Review prior diagnostic studies. Reexamine patient to make sure that physical findings have not changed and update H&P. Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient/family. Obtain informed consent. Change into scrub clothes. Review length and type of anesthesia with anesthesiologist. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Assist with patient positioning (typically prone jackknife or dorsal lithotomy) and prepping/draping as needed. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: The patient is placed in prone jack-knife position. A retractor system is utilized to evert the anal canal. A large anal retractor or rectal speculum is placed and a local anesthetic agent with epinephrine is injected into the submucosal plane of the lesion. Stay sutures are placed 1 cm proximal and 1 cm distal to the lesion. A 1 cm or greater margin is outlined around the entire lesion. An energy source (eg, electric cautery, harmonic scalpel) is utilized to begin the full thickness excision of the tumor. The posterior rectal wall is transected through the mucosa, muscular layer, lamina propria and then through the rectal mesentery. This is performed circumferentially around the lesion along the margin. The lesion is removed and sent to pathology. Hemostasis is obtained and the defect is closed.

Description of Post-Service Work: Discuss postoperative care with recovery room staff. Discuss surgery outcome with patient's family. Write brief operative note. Monitor patient stabilization in the recovery room. After patient is awake,

discuss surgery outcome with patient and examine patient to assess for the development of complications (eg, perforation, bleeding). Dictate operative report (copy PCP and/or referring physician) and complete medical record documentation. Correctly assign CPT codes including Physicians Quality and Reporting Initiative (PQRI) add-on codes where appropriate. Consider relevant data, options, and risks and make the decision to admit patient for continu hospital care. Write orders for transfer to medical floor. Visit and examine patient daily to assess wound healing bowel signs. Write orders for advancement of diet, medications, and bathing and activity restrictions. Discharge patient from hospital when relevant data, options, and risks indicate it is safe. Discuss at home treatment with the patient/family, including home restrictions, especially diet, activity, bathing. Reconcile medications and write orders for post-discharge medication. Complete all appropriate medical records, including discharge summary and discharge instructions, and insurance forms. A diagnostic sigmoidoscopy will be performed at one or more office visits to assess wound healing. Review pathology report with patient when available. Revise treatment plan(s) and communicate with patient and family/caregiver, as necessary. Discuss progress with PCP and/or referring physician (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Guy Orangio, MD, FACS; Christopher Senkowski, MD, FACS				
pecialty(s):	colon and rectal surgery; general surgery				
CPT Code:	45172				
Sample Size: 300	**Resp N:** 92	**Response:** 30.6 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	9.00	30.00
Survey RVW:	9.00	11.00	**12.00**	15.25	22.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	60.00	**75.00**	90.00	135.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	45172	**Recommended Physician Work RVU: 12.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
45190	090	10.29	RUC Time

CPT Descriptor Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal 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	Work RVU	Time Source	Most Recent Medicare Utilization
47562	090	11.63	RUC Time	118,151

CPT Descriptor 1 Laparoscopy, surgical; cholecystectomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 52 **% of respondents:** 56.5 %

TIME ESTIMATES (Median)	CPT Code: 45172	Key Reference CPT Code: 45190	Source of Time RUC Time
Median Pre-Service Time	75.00	80.00	
Median Intra-Service Time	75.00	60.00	
Median Immediate Post-service Time	20.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	62.0	62.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**290.00**	**266.00**	
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	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.48
Urgency of medical decision making	3.12	3.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.18	3.57
Physical effort required	3.59	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.39	3.05
Outcome depends on the skill and judgment of physician	4.12	3.69
Estimated risk of malpractice suit with poor outcome	3.41	3.12

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.55	3.31
Intra-Service intensity/complexity	3.71	3.24
Post-Service intensity/complexity	2.94	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.*

Current code 45170 (*Excision of rectal tumor, transanal approach*) will be deleted in 2010 and replaced by two new codes (G1 and G2). Code 45170 was reviewed twice by the RUC, resulting in survey data that indicated the typical patient stayed in the hospital for one or more nights. The code was selected for review by the RUC 5YR ID Workgroup screen for site of service anomalies. During review of the survey data for this code, the RUC determined, and the surveying specialties agreed, that code 45170 represented a bimodal distribution of patients and

that the code should be reviewed by CPT. The ASCRS and ACS presented a CCP for deletion of code 45170 and creation of two new codes (G1 and G2) that differentiated depth of excision for rectal tumors.

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change
- Positioning: Add 17 minutes to position the patient prone jackknife or in dorsal lithotomy.
- Scrub/Dress/Wait: no change

G2 Recommendation: The consensus committee recommends the survey median RVW of 12.00. This value is slightly less than the current RVW for 45170. This RVW is greater than the key reference code 45190 (RVW=10.29) which has less intra-operative time and less post-op work. The RVW of 12.00 is also similar to MPC code 47562 (RVW=11.63), which has similar intra-op time and slightly less post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 45170

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 colon and rectal surgerey How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 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 extrapolation from 2006 Medicare utilization

Specialty colon and rectal surgery Frequency 1800 Percentage 60.00 %

Specialty general surgery Frequency 1200 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate based on 2006 Medicare utilization of 45170

Specialty colon and rectal surgery Frequency 1200 Percentage 60.00 %

Specialty general surgery Frequency 800 Percentage 40.00 %

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. Suggest using the PLI for current code 45170. Although the intra-time is significantly less than new code G2, the previous RVW is similar to the recommendation. We were not able to identify another 90-day global code that is familiar to colon and rectal surgeons and general surgeons for malignant tumor excision that has an RVW this low.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptors:

45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)
45172	Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)

Sample Size: **N/A**

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 committee of general surgeons and colon and rectal surgeons representing all types of practices and all geographic settings discussed the practice expense details for new codes G1 and G2. The consensus was that neither of these codes should be priced in the office setting. Additionally, the committee agreed that at least one of the follow-up office visits, a sigmoidoscopy would be performed to assess wound healing.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information including instructions on diet and bowel cleansing prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities
Discharge management and office visit related activities are performed. Additionally, 35 minutes (standard) for setting up and cleaning the scope at one visit have been added to the standard office visit times that do not include these additional activities.

	A	B	C	D	E	F	G
1				G1		G2	
2				45171		45172	
3	**AMA/Specialty Society RVS Update Committee Recommendation**			Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)		Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)	
4	**LOCATION**	**Code**	**Staff Type**	**Office**	**Facility**	**Office**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**175**	**n/a**	**181**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**60**	**n/a**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**6**	**n/a**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**109**	**n/a**	**109**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA		**5**		**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA		**20**		**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**		**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**20**		**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**7**		**7**
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
39	Discharge day mgmt 99238 –12 min, 99239 –15 min	**L037D**	RN/LPN/MTA		**6**		**12**
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27		**1**		**1**
49	99213 36 minutes		36		**2**		**2**
50	99214 53 minutes		53				
51	99215 63 minutes		63				
53	*Total Office Visit Time*	**L037D**	RN/LPN/MTA	**0**	**99**	**0**	**99**
54	Other: Setting up & Cleaning rigid Sig Scope at 1 visit				**10**		**10**
55	**End: with last office visit before end of global period**						
56	**MEDICAL SUPPLIES**	**Code**	**Unit**				
57	pack, minimum multi-specialty visit	**SA048**	**pack**		**3**		**3**
58	mask, surgical, with face shield	**SB034**	**item**		**4**		**4**
59	gown, staff, impervious	**SB027**	**item**		**4**		**4**
60	shoe covers, surgical	**SB039**	**pair**		**2**		**2**
61	underpad 2ft x 3ft (Chux)	**SB044**	**item**		**1**		**1**
62	tubing, suction, non-latex (6ft uou)	**SD132**	**item**		**1**		**1**
63	tubing, suction, non-latex (6ft) with Yankauer tip (1)	**SD134**	**item**		**1**		**1**
64	canister, suction	**SD009**	**item**		**1**		**1**
65	syringe 50-60ml	**SC056**	**item**		**1**		**1**
66	lubricating jelly (K-Y) (5gm uou)	**SJ032**	**item**		**6**		**6**
67	swab, procto 16in	**SJ052**	**item**		**3**		**3**
68	applicator, cotton-tipped, non-sterile 6in	**SG008**	**item**		**3**		**3**
69	gauze, non-sterile 2in x 2in	**SG050**	**item**		**8**		**8**
70	pack, cleaning and disinfecting, endoscope	**SA042**	**pack**		**1**		**1**
71	**Equipment**	**Code**					
72	table, power	**EF031**			**99**		**99**
73	light, surgical	**EF014**			**99**		**99**
74	suction machine (Gomco)	**EQ235**			**36**		**36**
75	light source, xenon	**EQ167**			**36**		**36**
76	cart, endoscopy imaging equipment	**ES003**			**36**		**36**
77	endoscope, rigid, sigmoidoscopy	**ES012**			**46**		**46**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

April 2009

Urodynamics Studies

In February 2008, the RUC identified 51726, 51772, 51795, and 51797 through the Codes Reported Together screen as they are reported together more than 95% of the time. The RUC referred to all four codes to CPT for creation of new bundled services and to reorganize the coding structure to reflect the typical procedures performed.

51727
The RUC reviewed the physician time for 51727 *Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique* and determined that an additional 13 minutes of pre-time package 5 Non-Facility Procedure without anesthesia, is necessary to capture evaluation and the placement of the foley and urodynamic cathethers. The specialty society indicated that the total pre-service time of 20 minutes, as indicated by the survey respondents is correct, but should all be captured in the pre-evaluation component. The specialty society recommended and the RUC agreed that an additional 5 minutes should be added to the survey intra-service time of 30 minutes, totaling 35 minutes, as it requires slightly more time than base code 51726 *Complex cystometrogram (eg, calibrated electronic equipment)* (work RVU = 1.71 and physician time of 25 minutes pre-, 30 minutes intra- and 15 minutes immediate post-service time) to perform the urethral pressure profile studies. The specialty society recommended and the RUC agreed that the survey immediate post-service time of 10 minutes is appropriate.

The RUC compared 51727 to 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23 and 17 minutes pre, 15 minutes intra, and 10 minutes post time) and determined that urodynamics code 51727 is less intense. The RUC then reviewed reference code 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* (work RVU = 2.11 and 15 minutes pre, 35 minutes intra, and 10 minutes immediate post-service time) and determined that 2.11 work RVUs is an appropriate crosswalk as these two services have similar service times and intensities. The RUC also, compared 51727 to 99215 *Office Visit, Established Patient* (work RVU = 2.00 and 5 minutes pre, 35 minutes intra, and 15 minutes post time). **The RUC recommends 2.11 work RVUs for 51727 and 20 minutes pre, 35 minutes intra and 10 minutes immediate post-service time.**

51728
The RUC reviewed code 51728 *Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique* and determined that it requires the same physician work and physician time as 51727.

The RUC reviewed the physician time for 51728 and determined that an additional 13 minutes to pre-time package 5 Non-Facility Procedure without anesthesia, is necessary to capture evaluation and the placement of the foley and urodynamic cathethers. The specialty society indicated that the total pre-service time of 20 minutes, as indicated by the survey respondents is correct, but should all be captured in the pre-evaluation component. The specialty society recommended and the RUC agreed that an additional 5 minutes should be added to the surveyed intra-service time of 30 minutes, totaling 35 minutes, as it requires slightly more time than base code 51726 *Complex cystometrogram (eg, calibrated electronic equipment)* (work RVU = 1.71 and physician time of 25 minutes pre-, 30 minutes intra- and 15 minutes immediate post-service time) to perform the voiding pressure studies. The specialty society recommended and the RUC agreed that the survey immediate post-service time of 10 minutes is appropriate.

The RUC compared 51728 to 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23 and 17 minutes pre, 15 minutes intra, and 10 minutes post time) and determined that urodynamics code 51727 is less intense. The RUC then reviewed reference code 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* (work RVU = 2.11 and 15 minutes pre, 35 minutes intra, and 10 minutes immediate post-service time) and determined that 2.11 work RVUs is an appropriate crosswalkas these two services have similar service times and intensities. The RUC also, compared 51727 to 99215 *Office Visit, Established Patient* (work RVU = 2.00 and 5 minutes pre, 35 minutes intra, and 15 minutes post time). **The RUC recommends 2.11 work RVUs for 51728 and 20 minutes pre, 35 minutes intra and 10 minutes immediate post-service time.**

1395

51729
The RUC reviewed the physician time for 51729 *Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), and urethral pressure profile studies (ie, urethral closure pressure profile), any technique* and determined that an additional 13 minutes to pre-time package 5 Non-Facility Procedure without anesthesia, is necessary to capture evaluation and the placement of the foley and urodynamic cathethers. The specialty society indicated that the total pre-service time of 20 minutes should all be captured in the pre-evaluation component. The specialty society recommended and the RUC agreed that an additional 10 minutes should be added to the surveyed intra-service time of 30 minutes, totaling 40 minutes, as it requires slightly more time than base code 51726 *Complex cystometrogram (eg, calibrated electronic equipment)* (work RVU = 1.71 and physician time of 25 minutes pre-, 30 minutes intra- and 15 minutes immediate post-service time) and slightly more physician time to perform than the urethral pressure studies and the voiding pressure studies alone. The specialty society recommended and the RUC agreed that the survey immediate post-service time of 15 minutes is appropriate.

The RUC reviewed the increment between the base code 51726 and the recommended work RVUs for 51727 or 51728, which was 0.40 (2.11 - 1.71 = 0.40). The RUC determined that 0.40 is an appropriate increment between 51727 or 51728 compared to 51729. The RUC added the increment and determined 2.51 work RVUs for 51729 appropriately accounts for the physician work required to perform this service (2.11 + 0.40 = 2.51). The RUC also compared 51729 to a similar service 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 10 minutes pre, 45 minutes intra, and 15 minutes immediate post-service time) and determined that this reference also supports a work RVU of 2.51 for code 51729. **The RUC recommends a work RVU of 2.51 for 51729 and 20 minutes pre, 40 minutes intra and 15 minutes immediate post-service time.**

Practice Expense
The RUC reviewed the clinical labor inputs for the typical patient and made minor edits regarding the intra-service time. The RUC also made adjustments to the medical supplies and equipment.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

1396

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
51726		Complex cystometrogram (ie, calibrated electronic equipment);	000	1.71 (No Change)
•51727	DD1	with urethral pressure profile studies (ie, urethral closure pressure profile), any technique	000	2.11
•51728	DD2	with voiding pressure studies (ie, bladder voiding pressure), any technique	000	2.11
•51729	DD3	with voiding pressure studies (ie, bladder voiding pressure), and urethral pressure profile studies (ie, urethral closure pressure profile), any technique	000	2.51
D 51772		~~Urethral pressure profile studies (UPP) (urethral closure pressure profile), any~~	000	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~technique~~ (51772 has been deleted. To report urethral pressure profile studies, use CPT codes 51727 or 51729)		
D 51795		~~Voiding pressure studies (VP); bladder voiding pressure, any technique~~ (51795 has been deleted. To report bladder voiding pressure studies, use code 51728 or 51729.)	000	N/A
E +51797		Voiding pressure studies, ~~(VP);~~ intra-abdominal ~~voiding pressure (AP)~~ (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure) ~~(Use 51797 in conjuncton with 51795)~~	ZZZ	0.80 (No Change)

1397

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:51727 Tracking Number DD1 Specialty Society Recommended RVU: **2.52**

Global Period: 000 RUC Recommended RVU: **2.11**

CPT Descriptor: Complex cystometrogram (eg, calibrated electronic equipment); with urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old woman complains of urinary stress incontinence 6-months after undergoing an anti-incontinence operation.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (3) positioning, prepping and draping the patient, and scrubbing; (4) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Connect catheter to infusion pump and pressure transducer and zero transducer to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work: This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiological landmarks. Wait for involuntary detrusor contractions as the bladder fills and record volume and pressure measurements. If involuntary detrusor contractions occur, evidence by voiding around the catheter, the bladder should be emptied. In some instances, the examination needs to be repeated in sitting and standing positions. If in involuntary detrusor contractions are not demonstrated, assist patient to sitting and/or standing position and repeat infusion. When ready to measure urethral measure profile, begin to withdraw catheter through the urethra and record bladder sensations and bladder volume at predefined physiologic landmarks. Each rise in urethral pressure must be accounted for by careful observations and annotated. When intra-urethral pressure is at its maximum, then have patient do sustained Valsalsa maneuver and several coughs and record changes to urethral pressures. Check patient for stress incontinence.

Description of Post-Service Work: (1) all post procedure care on the day of the procedure, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable. review, interpret and dictate results of the diagnostic study.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	James Giblin, MD; Richard Gilbert, MD, Kristi Keil, MD; George Hill, MD		
pecialty(s):	Urology/Gynecology		
CPT Code:	51727		
Sample Size:	106	**Resp N:** 46	**Response:** 43.3 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	17.50	**80.00**	150.00	650.00
Survey RVW:	1.01	2.77	**4.13**	6.33	12.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	20.00	**30.00**	30.00	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	51727	**Recommended Physician Work RVU: 2.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**7.00**	**13.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
ffice time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
52282	000	6.39	**RUC Time**

CPT Descriptor Cystourethroscopy, with insertion of urethral stent

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	92,211

CPT Descriptor 1 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43235	000	2.39	**RUC Time**	445,317

CPT Descriptor 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 19.5 %

TIME ESTIMATES (Median)	**CPT Code: 51727**	**Key Reference CPT Code: 52282**	**Source of Time RUC Time**
Median Pre-Service Time	20.00	40.00	
Median Intra-Service Time	35.00	50.00	
Median Immediate Post-service Time	10.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**65.00**	**120.00**	

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	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	3.11
Urgency of medical decision making	2.56	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.44
Physical effort required	3.56	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.56	3.56
Outcome depends on the skill and judgment of physician	4.44	3.67
Estimated risk of malpractice suit with poor outcome	2.78	3.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.22	2.89
Intra-Service intensity/complexity	4.00	3.11
Post-Service intensity/complexity	3.44	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an INPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The expert panel reviewed the physician work associated with this proposed CPT code and made the following determination due to the lack of compelling evidence:

The recommended work value by the specialty society was determined based on 2009 RVU for 51726 plus 50% of the RVU for 51772. This 50% reduction is based on the multiple procedure reduction payment rule for CPT codes reported during the same encounter. The recommendation is as follows:

CURRENT RVUs			CURRENT INTRA-SERVICE TIME			2009 RVU plus Multiple procedu reduction payment rule (50% reduction on second & third CPT codes)
	RUC	50%*	RUC	50%	TOTAL	51727 (51726 + 51772)
51726	1.71		30			1.71 + 0.81 = 2.52
51772	1.62	0.81	20	10	40	Recommended RVU = 2.52

In addition, the intra-service time should reflect 50% of the second CPT code as well.

SERVICES REPORTED WITH MULTIPLE 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 table at end of SOR

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 51726 + 51772

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 Gynecology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 78998

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Incontinence is frequently an issue for patients who are too young to be in Medicare.

Specialty Urology Frequency 49944 Percentage 63.22 %

Specialty Gynecology Frequency 23715 Percentage 30.01 %

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? 39,499 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Taken from the 2007 RUC database

Specialty Urology Frequency 24972 Percentage 63.22 %

Specialty Gynecology Frequency 11854 Percentage 30.01 %

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. 54231 (RVU of 2.04) Selected key reference code RVUs were too high and a new crosswalk was selected to reflect a more appropriate RVU.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Question #2. Services reported with multiple procedure codes

CPT Code	Descriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Multiple Procedure Reduction	50% RVU
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	000	1.14	13	28	13	Y	.57
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	0000	1.53	10	20	10	Y	.76
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	XXX	0	5	4	0	N	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:51728 Tracking Number DD2 Specialty Society Recommended RVU: **2.48**

Global Period: 000 RUC Recommended RVU: **2.11**

CPT Descriptor: Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69-year-old man complains of urinary frequency, urgency, weak stream and a post void residual urine of 210 ml.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (3) positioning, prepping and draping the patient, and scrubbing; (4) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Connect catheter to infusion pump and pressure transducer and zero transducer to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work: This is an interactive examination between patient and examiner. The procedural steps vary considerable depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiologic landmarks. Wait for involuntary detrusor contractions as the bladder fills and record volume and pressure measurements. If involuntary detrusor contractions occur, evidenced by voiding around the catheter, the bladder should be emptied. In some instances, the examination needs to be repeated in sitting and/or standing positions. If in involuntary detrusor contractions are not demonstrated, assist patient to sitting and/or stand position and repeat infusion. Ask the patient to try to void when he feels full. Each rise in vesical pressure must accounted for by careful observations. To distinguish detrusor contractions from rises in abdominal pressure. If detrusor contractions are not demonstrated, assist patient with provocative maneuvers such as turning on water on running water or helping him relax. If still unable to void, terminate the examination. Voiding is monitored to determine

peak voiding pressure. Abdominal straining is also assessed, as is quality of the detrusor contraction. Residual urine volume is calculated after voiding is completed.

Description of Post-Service Work: (1) all post procedure care on the day of the procedure, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable. (3) review, interpret and dictate results of the diagnostic study.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	James Giblin, MD; Richard Gilbert, MD, Kristi Keil, MD; George Hill, MD				
Specialty(s):	Urology/Gynecology				
CPT Code:	51728				
Sample Size:	106	**Resp N:**	50	**Response:** 47.1 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**100.00**	200.00	700.00
Survey RVW:	1.35	3.03	**4.33**	6.08	15.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	20.00	**30.00**	35.00	60.00

Immediate Post Service-Time:	**12.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	51728	**Recommended Physician Work RVU: 2.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**7.00**	**13.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
52007	000	3.02	**RUC Time**

CPT Descriptor Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43239	000	2.87	**RUC Time**	1,382,322

CPT Descriptor 1 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45378	000	3.69	**RUC Time**	971,248

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 51728**	**Key Reference CPT Code: 52007**	**Source of Time RUC Time**
Median Pre-Service Time	20.00	38.00	
Median Intra-Service Time	35.00	45.00	
Median Immediate Post-service Time	10.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**65.00**	**113.00**	

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	3.64	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	2.91
Urgency of medical decision making	2.55	2.55

Technical Skill/Physical Effort (Mean)

Technical skill required	2.91	3.00
Physical effort required	2.55	2.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.36
Outcome depends on the skill and judgment of physician	3.36	3.18
Estimated risk of malpractice suit with poor outcome	1.82	1.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.55	2.36
Intra-Service intensity/complexity	3.45	2.91
Post-Service intensity/complexity	2.73	2.45

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 Valu Recommendations for the appropriate formula and format.*

The expert panel reviewed the physician work associated with this proposed CPT code and made the following determination due to the lack of compelling evidence:

The recommended work value by the specialty society was determined based on 2009 RVU for 51726 plus 50% of the RVU for 51795. This 50% reduction is based on the multiple procedure reduction payment rule for CPT codes reported during the same encounter. The recommendation is as follows:

CURRENT RVUs			CURRENT INTRA-SERVICE TIME			2009 RVU plus Multiple procedure reduction payment rule (50% reduction on second & third CPT codes)
	RUC	50%*	RUC	50%	TOTAL	51728 (51726 + 51795)
51726	1.71		30			1.71 + 0.77 = 2.48
51795	1.53	0.77	25	12.5	40.5	

In addition, the intra-service time should reflect 50% of the second CPT code as well.

SERVICES REPORTED WITH MULTIPLE 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) Patients who present with specific clinical situations may require a battery of diagnostic testing to determine the proper diagnosis. The required testing is different and determined by the physician based on the clinical situation specific to the patient and their presenting problems.

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 table at end of SOR

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 51726 +51795

ow 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 Gynecology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 98748
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Incontinence is as frequently an issue for patients who are too young to be in Medicare.

Specialty Urology Frequency 62212 Percentage 63.00 %

Specialty Gynecology Frequency 36536 Percentage 36.99 %

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? 362,929 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From 2007 RUC database

Specialty Urology Frequency 265519 Percentage 73.16 %

Specialty Gynecology Frequency 170831 Percentage 47.07 %

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. 54231 is more appropriate

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Procedures reported with several CPT codes

2.

CPT Code	Descriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Multiple Procedure Reduction	50% RVU
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	000	1.14	13	28	13	Y	.57
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	0000	1.53	10	20	10	Y	.76
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	XXX	0	5	4	0	N	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:51729 Tracking Number DD3 Specialty Society Recommended RVU: **3.29**

Global Period: 000 RUC Recommended RVU: **2.51**

CPT Descriptor: Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique, and urethral pressure profile studies (UPP) (Urethral closure pressure profile), any technique

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old male status post radical retropubic prostatectomy 2 years ago complains of urinary frequency, weak stream and urinary incontinence. His post void residual urine is 208 ml.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (3) positioning, prepping and draping the patient, and scrubbing; (4) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Connect catheter to infusion pump and pressure transducer and zero transducer to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work: This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiologic landmarks. Wait for involuntary detrusor contractions as the bladder fills and record volume and pressure measurements. If involuntary detrusor contractions occur, evidenced by voiding around e catheter, the bladder should be emptied. In some instances, reexamination needs to be repeated in sitting and/or anding positions. If in involuntary detrusor contractions are not demonstrated, assist patient to sitting and/or standing position and repeat infusion. Ask the patient to try to void when he feels full.

Each rise in vesical pressure must be accounted for by careful observations to distinguish detrusor contractions from rises in abdominal pressure. If detrusor contractions are not demonstrated, assist patient with provocative maneuvers

such as turning on water on running water or helping him relax. When ready to measure urethral pressure profile, begin to withdraw catheter through the urethra and record bladder sensations and bladder volume at predefined physiologic landmarks. Each rise in urethral pressure must be accounted for by careful observations and annotated. When intra-urethral pressure is at its maximum, then have patient do sustained Valsalsa maneuver and several coughs and rec changes to urethral pressures. Check patient for stress incontinence. Voiding is monitored to determine peak voi pressure. Abdominal straining is also assessed, as is quality of the detrusor contraction. Residual urine volume is calculated after voiding is completed.

Description of Post-Service Work: (1) all post procedure care on the day of the procedure, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable. (3) review, interpret and dictate results of the diagnostic study.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	James Giblin, MD; Richard Gilbert, MD, Kristi Keil, MD; George Hill, MD		
Specialty(s):	Urology/Gynecology		
CPT Code:	51729		
Sample Size:	106	**Resp N:** 45	**Response:** 42.4 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**100.00**	170.00	700.00
Survey RVW:	1.57	3.70	**5.70**	6.99	15.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	25.00	**30.00**	40.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	51729	**Recommended Physician Work RVU: 3.29**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**7.00**	**13.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
fice time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
52282	000	6.39	**RUC Time**

CPT Descriptor Cystourethroscopy, with insertion of urethral stent

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	92,574

CPT Descriptor 1 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45380	000	4.43	**RUC Time**	778,737

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 28.8 %

TIME ESTIMATES (Median)	CPT Code: 51729	Key Reference CPT Code: 52282	Source of Time RUC Time
Median Pre-Service Time	20.00	40.00	
Median Intra-Service Time	40.00	50.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**75.00**	**122.00**	
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	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	3.40
Urgency of medical decision making	2.93	3.13

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	3.47
Physical effort required	3.47	2.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.07	3.40
Outcome depends on the skill and judgment of physician	4.60	3.40
Estimated risk of malpractice suit with poor outcome	3.13	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.73	2.93
Intra-Service intensity/complexity	4.20	3.40
Post-Service intensity/complexity	3.60	2.87

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The expert panel reviewed the physician work associated with this proposed CPT code and made the following determination due to the lack of compelling evidence:

The recommended work value by the specialty society was determined based on 2009 RVU for 51726 plus 50% of the RVU for 51772 and 51795. This 50% reduction is based on the multiple procedure reduction payment rule for CPT codes reported during the same encounter. The recommendation is as follows:

	CURRENT RVUs		CURRENT INTRA-SERVICE TIME			2009 RVU plus Multip procedure reduction payment rule (50% reduction on second & third CPT codes)
	RUC	50%*	RUC	50%	TOTAL TIME	51729 (51726 + 51772 + 51795)
51726	1.71		30			1.71 + 0.81 + 0.77 = 3.29
51772	1.62	0.81	20	10		
51795	1.53	0.77	25	12.5	52.5	

In addition, the time should reflect 50% of the current codes as well for the second and third 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: 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 table at end of SOR.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 51726 + 51772 + 51795

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 Gynecology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 118498

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Incontinence is frequently an issue for patients who are too young to be in Medicare.

pecialty Urology Frequency 78636 Percentage 66.36 %

Specialty Gynecology Frequency 31793 Percentage 26.82 %

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? 59,249 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. From the 2007 RUC database

Specialty Urology Frequency 39319 Percentage 66.36 %

Specialty Gynecology Frequency 15897 Percentage 26.83 %

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. CPT Code 55700 -- Selected key reference code RVUs were too high and a new crosswalk was selected to reflect a more appropriate RVU.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Question #2: Services reported with multiple CPT codes

CPT Code	Descriptor	Global	Work RVU	Pre Time	Intra Time	Post Time	Multiple Procedure Reduction	50% RVU
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	000	1.14	13	28	13	Y	.57
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	000	1.53	10	20	10	Y	.76
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	XXX	0	5	4	0	N	

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Complex cystometrogram (eg, calibrated electronic equipment); with urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique

Sample Size: 106 Response Rate: 43.3 % Global Period: 000

Geographic Practice Setting %: Rural 20% Suburban 45% Urban 35%

Type of Practice %:
__25%__ Solo Practice
__45%__ Single Specialty Group
__20%__ Multispecialty Group
__10%__ 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 recommendations were developed by a Panel consisting of eight physicians who represents urological and gynecological practices from across the United States in a single specialty groups in suburban and urban settings. They represent the states of Washington, New York, Florida, Virginia, Tennessee, Mississippi, Colorado and Illinois.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Set up and calibrate urodynamics equipment
- Prepare and position patient/monitor patient
- Apply anesthesia
- Catheterize the patient for post void residual urine
- Insert catheters and apply electrodes
- Check for resting pressures in patient before testing begins

Intra-Service Clinical Labor Activities:
- Discuss with physician and assist in determining the type of testing to be performed.
- Fill the bladder as required during the diagnostic study
- Discuss with the physician the findings of the study as it progresses

- Continuously monitor the vesicle, detrusor, voiding volume and voiding pressures
- Assist patient for standing and coughing phase to monitor pressures
- Discuss the findings with the physician to determine if any other diagnostic procedure needs to be performed
- Unhook the patient from the urodynamics equipment

Post-Service Clinical Labor Activities

- Assist patient in eliminating urine from bladder
- Clean room and instruments
- Clean urodynamics equipment
- Complete diagnostic forms
- Coordinate homecare instructions, prescriptions and follow up office visits

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique

Sample Size:106_____ Response Rate: 47.1%_____ Global Period:_000____

Geographic Practice Setting %: Rural 20% Suburban 45% Urban 35%

Type of Practice %: __25%__ Solo Practice
__45%___Single Specialty Group
__20% ___Multispecialty Group
__10%___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:
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- Check for resting pressures in patient before testing begins

Intra-Service Clinical Labor Activities:
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- Fill the bladder as required during the diagnostic study
- Discuss with the physician the findings of the study as it progresses
- Continuously monitor the vesicle, detrusor, voiding volume and voiding pressures
- Assist patient for standing and coughing phase to monitor pressures
- Discuss the findings with the physician to determine if any other diagnostic procedure needs to

be performed
- Unhook the patient from the urodynamics equipment

Post-Service Clinical Labor Activities
- Assist patient in eliminating urine from bladder
- Clean room and instruments
- Clean urodynamics equipment
- Complete diagnostic forms
- Coordinate homecare instructions, prescriptions and follow-up office visits

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Complex cystometrogram (eg, calibrated electronic equipment); voiding pressure studies (VP); bladder voiding pressure, any technique, and urethral pressure profile studies (UPP) (Urethral closure pressure profile), any technique

Sample Size: 106 Response Rate: 42.4 % Global Period: 000

Geographic Practice Setting %: Rural 20% Suburban 45% Urban 35%

Type of Practice %:
__25%__ Solo Practice
__45%___Single Specialty Group
__20%___Multispecialty Group
__10%___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 recommendations were developed by a Panel consisting of eight physicians who represents urological and gynecological practices from across the United States in a single specialty groups in suburban and urban settings. They represent the states of Washington, New York, Florida, Virginia, Tennessee, Mississippi, Colorado and Illinois.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
- Review charts
- Greet patient and provide gowning
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- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Set up and calibrate urodynamics equipment
- Prepare and position patient/monitor patient
- Apply anesthesia
- Catheterize the patient for post void residual urine
- Insert catheters and apply electrodes
- Check for resting pressures in patient before testing begins

Intra-Service Clinical Labor Activities:
- Discuss with physician and assist in determining the type of testing to be performed.
- Fill the bladder as required during the diagnostic study
- Discuss with the physician the findings of the study as it progresses
- Continuously monitor the vesicle, detrusor, voiding volume and voiding pressures

- Assist patient for standing and coughing phase to monitor pressures
- Discuss the findings with the physician to determine if any other diagnostic procedure needs to be performed
- Unhook the patient from the urodynamics equipment

Post-Service Clinical Labor Activities

- Assist patient in eliminating urine from bladder
- Clean room and instruments
- Clean urodynamics equipment
- Complete diagnostic forms
- Coordinate homecare instructions, prescriptions and follow up office visits

	A	B	C	D	E	F	G	H	
1				51727		51728		51729	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Complex cystometrogram (eg, calibrated electronic equipment); with urethral pressure profile studies (UPP) urethral closure pressure profile), any technique		Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique		Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique, and urethral pressure profile studies (UPP) urethral closure pressure profile), any technique	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD	000	Blend						
5	TOTAL CLINICAL LABOR TIME		L037D	90.0		90.0		95.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME		L037D	0.0		0.0		0.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		L037D	90.0		90.0		95.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME		L037D	0.0		0.0		0.0	
9	PRE SERVICE		L037D						
10	Start: Following visit when decision for surgery or procedure made		L037D						
11	Complete pre-service diagnostic & referral forms		L037D	0		0		0	
12	Coordinate pre-surgery services		L037D	0		0		0	
13	Schedule space and equipment in facility		L037D	0		0		0	
14	Provide pre-service education/obtain consent		L037D	0		0		0	
15	Follow-up phone calls & prescriptions		L037D	0		0		0	
16	Other Clinical Activity (please specify)		L037D						
17	End: When patient enters office/facility for surgery/procedure		L037D						
18	SERVICE PERIOD		L037D						
19	Start: When patient enters office/facility for surgery/procedure: Services P		L037D						
20	Review charts		L037D	3		3		3	
21	Greet patient and provide gowning		L037D	3		3		3	
22	Obtain vital signs		L037D	3		3		3	
23	Provide pre-service education/obtain consent		L037D	3		3		3	
24	Prepare room, equipment, supplies		L037D	2		2		2	
25	Setup urodynamics equipment (non facility setting only)		L037D	15		15		15	
26	Prepare and position patient		L037D	2		2		2	
27	Insert catheters and apply electrodes		L037D	5		5		5	
28	Sedate/apply anesthesia		L037D						
29	Intra-service		L037D						
30	Assist physician in performing procedure		L037D	35		35		40	
31	Post-Service		L037D						
32	Monitor pt. following service/check tubes, monitors, drains		L037D						
33	Clean room/equipment by physician staff		L037D	3		3		3	
34	Clean Urodynamics Equipment		L037D	10		10		10	
35	Clean Surgical Instrument Package		L037D						
36	Complete diagnostic forms, lab & X-ray requisitions		L037D						
37	Review/read X-ray, lab, and pathology reports		L037D						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		L037D	6		6		6	
39	Discharge day management		L037D						
40	Other Clinical Activity (please specify)								
41	End: Patient leaves office								
42	POST SERVICE PERIOD								
43	Start: Patient leaves office/facility			0		0		0	
44	Conduct phone calls/call in prescriptions								
45	*Office visits:*								
46	*List Number and Level of Office Visits*								
52	Other								
53	*Total Office Visit Time*			0	0	0	0	0	0
54	Other Activity (please specify)								

1444

	A	B	C	D	E	F	G	H	I
1				51727		51728		51729	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Complex cystometrogram (eg, calibrated electronic equipment); with urethral pressure profile studies (UPP) urethral closure pressure profile), any technique		Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique		Complex cystometrogram (eg, calibrated electronic equipment); with voiding pressure studies (VP); bladder voiding pressure, any technique, and urethral pressure profile studies (UPP) urethral closure pressure profile), any technique	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
55	End: with last office visit before end of global period								
56	MEDICAL SUPPLIES		Unit						
57	Catheter, pressure, urodynamics	SD027	Item	1		1		1	
58	Transducer dome (pressure)	SD125	Item	2		2		2	
59	Electrode, surface	SD062	Item	3		0		3	
60	Tubing, latex	SD130	foot	3		0		3	
61	Tubing, for pump head	SD128	Item	1		1		1	
62	Tubing, pressure	SD131	Item	2		2		2	
63	Drape-towel, sterile 18 in x 26 in	SB019	Item	3		3		3	
64	Underpad 2 ft x 3 ft (Chux)	SB044	Item	3		3		3	
65	IV infusionset	SC018	Item	1		1		1	
66	Needle, 18-27g	SC029	Item	1		1		1	
67	Syringe 10-12 ml	SC051	Item	3		3		3	
68	Pack, minimum multi-specialty visit	SA048	pack	1		1		1	
69	Pack, urology cystoscopy visit	SA058	pack	1		1		1	
70	Tray, catheter insertion (w-o catheter)	SA063	tray	1		1		1	
71	Patient education booklet	SK062	Item	1		1		1	
72	Tape, surgical paper 1 in (Micropone)	SG079	Inch	12		12		12	
73	Beaker, 250ml	SL018	Item	0		1		1	
74	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	Item	1		1		1	
75	catheter, straight	SD030	Item	1		1		1	
76	catheter, balloon, rectal pressure	SD017	Item	1		1		1	
77	Gloves, non-sterile	SB022	pair	4		4		4	
78	Gloves, sterile	SB024	pair	2		2		2	
79	Lidocaine 2% jelly, topical (Xolocaine)	SH047	ml	10		10		10	
80	Sanitizing cloth wipe (patient)	SM021	Item	5		5		5	
81	Paper Towels (bounty, per sheet)	SK082	Item	5		5		5	
82	Disenfectant, surface (Envirocide, Sanizide)	SM013	Item	1		1		1	
83	EQUIPMENT								
84	Table, power	EF031		1		1		1	
85	Urodynamics system, 6 chan.	EQ258		1		1		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five-Year Review

February and April 2009

Neurostimulator (Spinal)

The RUC identified 63660, *Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)* in its Site of Service Anomaly screen and recommended that it be referred to the CPT Editorial Panel for revision. CMS identified 63655, *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* through the CMS Fastest Growing Procedures screen and recommended that the RUC survey this service. At its October 2008 meeting, the CPT Editorial Panel deleted 63660 and created four new services to describe the work previously reported using 63660. The specialty societies requested a global period change for 63661, *Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* and 63663, *Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* from 090 day to 010 day global periods. CMS agreed with this request however, due to a late start, the specialty societies requested and RUC agreed to allow the presentation of this issue at the April 2009 RUC meeting to allow for more time to conduct the surveys and obtain an optimal number of responses.

1446

The specialty society provided some evidence to the RUC that incorrect assumptions were made in the previous valuation of 63660, including a misleading vignette, survey and flawed crosswalk assumption. The specialty commented that code 63660 was simply too broad to be able to provide a valid measure of the work. However, the RUC did not agree that the information provided by the specialty show that the work had changed significantly. Therefore, the RUC assumes that the new family of services will be work neutral as consistent with RUC/CMS standards. The specialty also provided some evidence that the length of hospital stay for 63655 had changed since the last time is was valued and that the current value for the procedure is anomalous with other codes in the family. Specifically, the specialty stated that the current intra-service work per unit of time (IWPUT) is 0.03 whereas other similar codes have IWPUTs of roughly 0.08. The RUC did not agree that this information met the compelling evidence standards to consider increases in the work RVU of 63655. The RUC reviewed the specialty society survey data to appropriately calculate the relativity between the four new codes as well as 63655 and made the following recommendations:

63655, *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*
The specialty society presented the data of a survey of 42 physicians. The survey median intra-service time was 90 minutes and the median work RVU was 13.00. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a typical length of stay of only one night. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit. Moreover, the specialty society reduced the number of post-operative office visits from the survey data to one 99212 and two 99213 office visits. The RUC agreed with these changes to the post-operative evaluation and management services. The specialty presented a recommendation of 11.51 RVUs to the RUC. The RUC also agreed that the survey results provide some evidence that the

current work RVU for 63655 of 11.43 is not too high. The RUC reviewed reference code 63030, *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar* (work RVU = 13.03) and noted that the surveyed code contains identical intra-service time as the reference code (90 minutes). However, 63030 contains more pre-service time (75 minutes vs. 63 minutes), more immediate post-service work (30 minutes vs. 20 minutes), one additional 99212, and one additional 99213 post-operative hospital visits. Given the similarities of the services and taking into account the differences in time and post-operative visits, the RUC agreed that a work RVU of 11.43 maintains proper rank order with other spine surgery procedures. **Therefore, the RUC recommends the specialty-recommended physician time and a work RVU of 11.43 for CPT code 63655.**

63661, Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
The RUC reviewed the survey results of 64 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a patient is typically discharged the same day. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit and recommended that only one-half 99238 discharge day management service be included. The RUC also agreed that the median physician work RVU of 5.30 placed 63661 in appropriate relativity within the family of 63655 and 63661 – 63664. The RUC reviewed reference code 62355, *Removal of previously implanted intrathecal or epidural catheter* (work RVU = 4.30, intra-service time = 30 minutes) and agreed that the two services are similar. However, the survey code contains a greater amount of intra-service time compared to the reference service (55 minutes and 30 minutes, respectively), which justifies a higher work RVU. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey median work RVU of 5.30 and resulted in a recommended work RVU of 5.03. **Therefore, the RUC recommends the calculated work RVU for 63661 of 5.03.**

63662, Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
The RUC reviewed the survey results of 35 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a typical length of stay of only one night. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit. The RUC also agreed that the survey 25th percentile physician work RVU of 11.45 placed 63662 in appropriate relativity within the family of 63661 – 63664. The RUC reviewed reference code 63030, *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar* (work RVU = 13.03, intra-service time = 90 minutes) and agreed that the two services are similar. However, the survey code contains a smaller amount of intra-service time compared to the reference service (60 minutes and 90 minutes, respectively), the survey code also contains less pre-service time (63 minutes vs 75 minutes), and no hospital visits, whereas the reference code contains two 99231 hospital visits. These differences account for the lower recommended work RVU for 63662. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey 25th percentile work RVU of 11.45 and resulted in a recommended work RVU of 10.87. **Therefore, the RUC recommends the calculated work RVU for 63662 of 10.87.**

63663, Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

The RUC reviewed the survey results of 52 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a patient is typically discharged the same day. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit and recommended that only one-half 99238 discharge day management service be included. The RUC also agreed that the median physician work RVU of 8.11 placed 63663 in appropriate relativity within the family of 63661 – 63664. The RUC reviewed reference code 63650, *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU = 7.15, intra-service time = 60 minutes) and agreed that the two services are similar. However, the survey code contains a greater amount of intra-service time compared to the reference service (90 minutes and 60 minutes, respectively), which justifies a slightly higher work RVU, maintaining rank order. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey median work RVU of 8.11 and resulted in a recommended work RVU of 7.70. **Therefore, the RUC recommends the calculated work RVU for 63663 of 7.70.**

63664, Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

The RUC reviewed the survey results of 32 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a typical length of stay of only one night. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit. The RUC also agreed that the survey 25th percentile physician work RVU of 12.00 placed 63664 in appropriate relativity within the family of 63661 – 63664. The RUC reviewed reference code 62351, *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy* (work RVU = 11.54, intra-service time = 90 minutes) and agreed that the two services are similar. The survey code contains an identical intra-service time compared to the reference service (90 minutes), but requires fewer post-operative hospital visits. The reference code requires a four 99233 hospital visits, whereas the survey code requires none. However, the survey code requires greater intensity and complexity, justifying a similar, though slightly lower work RVU, maintaining rank order. The RUC also noted that the physician time of 63664 is identical to the recommended survey time for 63655. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey 25th percentile work RVU of 12.00 and resulted in a recommended work RVU of 11.39. **Therefore, the RUC recommends the calculated work RVU for 63664 of 11.39.**

Practice Expense
The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

Work Neutrality Calculation
In order to maintain work neutrality between the new codes created through the deletion of 63660 (and bundling of 77002), the RUC recommends the below calculation. The total work RVUs of 63660 and 77002 are 42,859. However, the total projected work RVUs based on the non-adjusted recommendations exceeds the existing work RVUs by 5.3% (45,145). To maintain budget neutrality, the RUC multiplied each work RVU by 94.94%. The resulting values reflect the RUC's recommendations and maintain budget neutrality.

New Codes					
Code	**Work RVU**	**Frequency**	**RVU Impact**	**Work Neutrality Multiplier**	**Final Work RVU**
63661	5.30	1909	10,118	94.94%	**5.03**
63662	11.45	405	4,637	94.94%	**10.87**
63663	8.11	2892	23,454	94.94%	**7.70**
63664	12.00	578	6,936	94.94%	**11.39**
Total			**45,145**		
Existing Codes					
Code	**Work RVU**	**Frequency**	**RVU Impact**		
77002	0.54	5784	3,123		
63660	6.87	5784	39,736		
Total			**42,859**		
Work Neutrality Multiplier = 42,859 / 45,145 = 94.94%					

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 63650-63688 apply to both simple and complex neurostimlators. For initial or subsequent electrode analysis and programming of neurostimulator pulse generators, see codes 95970-95975. Codes 63650, 63655, and ~~63660~~ 63661-63664 describe the operative placement, revision, replacement or removal of the spinal neurostimulator system components to provide spinal electrical stimulation. A neurostimulator system includes an implanted neurostimulator, eternal controller, extension, and collection of contracts. Multiple contacts or electrodes (4 or more) provide the actual electrical stimulation in the epidural space. For percutaneously placed neurostimulator systems (63650, ~~63660,~~ 63661, 63663), the contacts are on a catheter-like lead. An array defines the collection of contacts that are on one catheter. For systems placed via an open surgical exposure, (63655, ~~63660,~~ 63662, 63664), the contacts are on a plate or paddle-shaped surface. (Do not report 63661 or 63663 when removing or replacing a temporary percutaneoulsy placed array(s) for an external generator)				
63655		Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	090	11.43 (No change)
D 63660		~~Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)~~ (Code 63660 has been deleted. To report, see 63661=- 63664)	090	N/A
●63661	I1	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	010	5.03
●63662	I2	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	090	10.87
●63663	I3	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed (Do not report code 63663 with codes 63661, 63662 for the same spinal level)	010	7.70

1450

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●63664	I4	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed (Do not report code 63664 with codes 63661, 63662 for the same spinal level)	090	11.39

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63655 Tracking Number Specialty Society Recommended RVU: **11.51**

Global Period: 090 RUC Recommended RVU: **11.43**

CPT Descriptor: Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old woman completed a successful trial of percutaneous spinal cord stimulation. the patient is to undergo laminectomy for placement of a permanent plate/paddle electrode from spinal cord stimulation

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Percent of survey respondents who stated they perform the procedure; In the hospital 90% , In the ASC 10%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 18% , Kept overnight (less than 24 hours) 55% , Admitted (more than 24 hours) 26%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 26%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 48%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 17%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Communicating with the referring physician and other health care professionals, and obtaining informed consent. The physician would obtain and review the previous operative note(s) and any pertinent radiographs and medical information regarding implant from the implant manufacturer or available medical records. Pre-service work also includes a focused examination of the patient, pre-operative scrubbing and positioning, prepping, and draping the patient. The results of preadmission testing are reviewed. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. The surgeon would meet with patient and family to review planned procedure and post-operative management, review and obtain informed consent.The surgeon would also review the type of anesthesia with anesthesiologist, verify that all required instruments and supplies are available, and assist with positioning the patient. The surgeon would also monitor/assist with draping and positioning of the patient. The surgeon would scrub and gown, and then perform the surgical "time out" with the operating and anesthesia team.

Description of Intra-Service Work: Once the "time out" procedure has been completed, the fluoroscopy unit is used to visualize the existing percutaneous leads. The skin over that site is marked and the midline infiltrated with local anesthetic. The skin incision is made and loup magnification used to dissect through the subcutaneous tissues. The quadratus lumborum fascia is opened and the paraspinous muscles are taken down to expose the T11-T12 spinous processes and lamina. The correct interspace is verified by intra-operative fluoroscopy. Rongeurs are then used to perform a laminectomy at this level. Bone edges are waxed to control bleeding and meticulous hemostasis is performed. The wound is irrigated with antibiotic irrigant. The percutaneous lead is removed and the paddle lead is unpackaged

and soaked in antibiotic solution. It is then placed into the epidural space under direct vision. Exact placement is verified by fluoroscopy and the leads are then anchored to the fascia to prevent migration. Impedance testing and stimulation is then performed to verify function of the leads. The implantation of the spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63685). The paddle lead is connected to the pu generator or receiver. A final fluoroscopic image is obtained and printed for the permanent record. The incision closed and dressings are applied..

Description of Post-Service Work: The patient is observed for stability of vital signs and comfort and then the operator communicates with the patient, family, and other health care professionals (including written and telephone reports and orders) and coordinates discharge day management. Additionally, all hospital visits and post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure. The surgeon would write prescriptions for medications needed after discharge and instructions, such as home restrictions (i.e., diet, activity, bathing, driving), are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge progress notes, discharge summary and discharge instructions, and insurance forms. The patient is discharged when there is return of adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation.
Office post-discharge work: Examine and talk with patient. Perform wound check. Remove sutures/staples if placed. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record. All post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Frederick Boop, MD, Charles Mick, MD, Alexander Mason, MD				
Specialty(s):	AANS/CNS, NASS				
CPT Code:	63655				
Sample Size: 1007	**Resp N:** 42	**Response:** 4.1 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	0.00	**2.00**	12.00	60.00
Survey RVW:	5.00	12.00	**13.00**	16.45	30.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	60.00	**90.00**	115.00	180.00

Immediate Post Service-Time:	**22.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	63655	**Recommended Physician Work RVU: 11.43**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**1.00**	**14.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**5.00**	**10.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
62351	090	11.54	RUC Time

CPT Descriptor Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63047	090	15.22	RUC Time	74,815

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60220	090	12.29	RUC Time	8,878

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 35.7 %

TIME ESTIMATES (Median)	CPT Code: 63655	Key Reference CPT Code: 62351	Source of Time RUC Time
Median Pre-Service Time	63.00	62.00	
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	0.0	165.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**273.00**	**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	3.60	3.34
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.47
Urgency of medical decision making	2.93	2.93

Technical Skill/Physical Effort (Mean)

Technical skill required	3.93	3.53
Physical effort required	3.27	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.87	3.67
Outcome depends on the skill and judgment of physician	4.13	3.87
Estimated risk of malpractice suit with poor outcome	3.87	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.27	3.27
Intra-Service intensity/complexity	3.67	3.60
Post-Service intensity/complexity	3.13	3.13

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.*

he specialties selected pre-service package 2B with modifications to account for additional time required for positioning and scrub/dress/wait. The additional time for positioning is necessary because of the care and caution that must be exercised when placing an intubated patient into a prone position. The additional scrub/dress/wait is indicated due to the time required for induction.

The specialties are recommending a calculated RVU of 11.51, which is less than the survey 25th percentile. The expert panel determined that the reference code of 63030 as was chosen by the survey respondents for 6366X2 was a more appropriate reference code than 62351 which was selected by the survey respondents. Code 62351 is valued for significant in-hospital time (3 x 99233) and a low iwput (0.022), and therefore is not the best choice to use a benchmark. Using 63030 as a more appropriate comparision code, the new value was arrived at by subtracting the va. of the hospital visits (two 99231's) associated with the 13.03 work RVU's assigned to code 63030 resulting in a recommended work RVU of 11.51 for code 63655 (13.03 - 1.52 = 11.51). The new calculated IWPUT is 0.070 which places this value within rank order within the laminectomy family of codes. The total calculated impact of this change is approximately $7500 per year.

The recommendation for the survey median is further validated by an IWPUT comparison:
63655 - with recommended RVUw and times has an IWPUT of 0.070, consistent with the other codes in this family. The recommended value also compares well with MPC code 60220 (12.29 RVUw), which has a similar intraservice time (90 minutes), similar total time (274 minutes)and slightly higher IWPUT of 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: 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) Insertion and replacement of the implanted spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63685)

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 63685; global is 010; Pre-service 48"; Intra-servic e 60"; Post-service 20"; Included within the 10 day global period are 99238 x 0.5 and 99213 x 1

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63655

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 Neurosurgery 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? 5226

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the national frequency would be twice that of the Medicare population. Code 63655 was reported to Medicare 2613 times in 2007. Percentage breakdowns come from the RUC database.

Specialty Neurosurgery Frequency 3654 Percentage 69.91 %

Specialty Orthopedic Surgery Frequency 1278 Percentage 24.45 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,613 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This represents the 2007 Medicare frequency. Percentage breakdowns come from the RUC database.

Specialty Neurosurgery Frequency 1827 Percentage 69.91 %

Specialty Orthopedic Surgery Frequency 639 Percentage 24.45 %

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. We recommend maintaining the current PLI RVUs for this 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:63661 Tracking Number I1 Specialty Society Recommended RVU: **5.30**

Global Period: 010 RUC Recommended RVU: **5.03**

CPT Descriptor: Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54 year-old man had a previous implantation of a dorsal column spinal stimulator for pain control with good coverage and control of pain in the affected area initially. Over time, the stimulator no longer provided coverage to the affected area despite revision and the thoracic epidural stimulator array is to be removed.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 69% , In the ASC 28%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 89% , Kept overnight (less than 24 hours) 11% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 60%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 53%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 17%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Communicating with the referring physician and other health care professionals, and obtaining informed consent. The physician would obtain and review the previous operative note(s) and any pertinent radiographs and medical information regarding implant from implant manufacturer or available medical records. Pre-service work also includes a focused examination of the patient and an update of the history and physical exam documentation. The physician would also monitor/assist with draping and positioning of the patient.

Description of Intra-Service Work: The anchoring site of the previous stimulator lead in the thoracolumbar spine is localized. The overlying soft tissue structures are anesthetized to the level of the lamina with local anesthetic. A midline incision is created and soft tissues dissected to expose the lead. The lead is cut at the site and removed from the epidural space via gentle traction. An image is obtained to document removal of the lead. Removal of the implanted spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63688). The overlying tissues are closed and the site bandaged.

Description of Post-Service Work: The patient is observed for stability of vital signs and comfort and then the operato. communicates with the patient, family, and other health care professionals (including written and telephone reports and orders) and coordinates discharge day management. The physician would write prescriptions for medications needed after discharge and instructions, such as home restrictions (i.e., diet, activity, bathing, driving), are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge

progress notes, discharge summary and discharge instructions, and insurance forms. The patient is discharged when there is return of adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation. Additionally, all hospital visits and post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure.

Office post-discharge work: Examine and talk with patient. Perform wound check. Remove sutures/staples if placed. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AANS/CNS, ASA, ISIS, NASS				
CPT Code:	63661				
Sample Size:	1007	**Resp N:**	64	**Response:** 6.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**3.00**	6.00	30.00
Survey RVW:	0.80	4.50	**5.30**	6.76	27.70
Pre-Service Evaluation Time:			**37.50**		
Pre-Service Positioning Time:			**12.50**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	38.75	**55.00**	90.00	180.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	63661	**Recommended Physician Work RVU: 5.02**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**55.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
62355	010	4.30	**RUC Time**

CPT Descriptor Removal of previously implanted intrathecal or epidural catheter

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20103	010	5.31	**RUC Time**	1,437

CPT Descriptor 1 Exploration of penetrating wound (separate procedure); extremity

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49320	010	5.09	**RUC Time**	8,890

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
63688	010	5.25	**RUC Time**

CPT Descriptor Revision or removal of implanted spinal neurostimulator pulse generator or receiver

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 29.6 %

TIME ESTIMATES (Median)	**CPT Code: 63661**	**Key Reference CPT Code: 62355**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	48.00	
Median Intra-Service Time	55.00	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	
edian Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	23.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**165.00**	**140.00**	
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	2.74	2.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.95
Urgency of medical decision making	2.37	2.47

Technical Skill/Physical Effort (Mean)

Technical skill required	3.11	3.16
Physical effort required	2.84	2.84

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.16	3.16
Outcome depends on the skill and judgment of physician	2.95	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.74	2.74
Intra-Service intensity/complexity	3.21	3.21
Post-Service intensity/complexity	2.53	2.63

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's Five Year Review Identification Workgroup has identified codes whose valuations include hospital inpatient and/or discharge services within their global period, but the site of service is no longer predominately in the inpatient setting. One of these codes is 63660 – Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)

The RUC recommended that this code (along with the other codes in the family) be reassigned to a 10 day global period and be re-surveyed. This has been done for codes 62350, 62355, 62360, 62361, 62362, 62365, 63650, 63685, and 63688. The multi-specialty expert panel convened to undertake the surveys determined that the current descriptor for code 63660 was too broad to be able to define the work and requested that the code go back to the CPT Editorial Panel with a proposal to split code 63660 into separate codes that will describe the distinct work involved in the revision and in the removal of a percutaneous electrode when compared to the revision or the removal of a "plate/paddle" electrode array. The result is four new codes. The two codes describing procedures on a percutaneous electrode have a 10 day global and the other two describing procedures on a plate/paddle electrode array maintain a 90 day global period and are performed in an in-patient setting.

The specialties determined that pre-service package 2B with modification was an appropriate package. The modification is identical to those approved for both reference services, namely, additional time for placing the patient into a prone position.

Removal of the existing lead can be difficult: the lead is often coiled and surrounded by scar tissue.

We compared the work associated with this service to the other codes in the family, which include the key reference service 62355 (selected by 19 participants) and code 63688 (the reference service selected by 16 participants). The IWPUT for code 62355 is 0.043 and the IWPUT for code 63688 is 0.041. Using median intra-and post –service times and adjusting the survey results downward to better reflect post-operative visits, the median RVUw of 5.30 yields an IWPUT of 0.042. These values place the code into proper alignment with the rest of the 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: 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) Removal of the implanted spinal neurostimulator pulse generator or receiver is separately reported

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 63688 - global 010 - RVUw 5.25 - Pre-service 48" - Intra-service 55" - Post -service 20 " Included within the 10 day global period are 99238 x 0.5 and 99213 x 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63660

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Sometimes
Specialty Interventional Pain Mgmt/Pain Mgmt	How often? Sometimes
Specialty Neurosurgery	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 3816
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 33% of the cases previously reported with code 63660 would be reported with 6366X1. We also estimate that the national frequency would be twice that of the Medicare population. Code 63660 was reported to Medicare 5,784 times in 2007. (5784*.33 = 1,908. 1,908 * 2 = 3816)
Percentage breakdowns come from the RUC database.

Specialty Anesthesiology	Frequency 1223	Percentage 32.04 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 1220	Percentage 31.97 %
Specialty Neurosurgery	Frequency 715	Percentage 18.73 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,909 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 33% of the cases previously reported with code 63660 would be reported with 6366X1. Code 63660 was reported to Medicare 5,784 times in 2007. (5784 * .33 = 1909)

Specialty Anesthesiology	Frequency 612	Percentage 32.05 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 610	Percentage 31.95 %
Specialty Neurosurgery	Frequency 358	Percentage 18.75 %

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:63662 Tracking Number I2 Specialty Society Recommended RVU: **10.40**

Global Period: 090 RUC Recommended RVU: **10.87**

CPT Descriptor: Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56 year-old woman had a previous implantation of a plate/paddle dorsal column spinal stimulator for pain control with good coverage and control of pain in the affected area. Over time, the stimulator no longer provided coverage to the affected area despite revision and the plate/paddle is to be removed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 3%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 38% , Kept overnight (less than 24 hours) 53% , Admitted (more than 24 hours) 9%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 32%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 54%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 11%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Communicating with the referring physician and other health care professionals, and obtaining informed consent. The physician would obtain and review the previous operative note(s) and any pertinent radiographs and medical information regarding implant from the implant manufacturer or available medical records. Pre-service work also includes a focused examination of the patient, pre-operative scrubbing and positioning, prepping, and draping the patient. The results of preadmission testing are reviewed. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. The surgeon would meet with patient and family to review planned procedure and post-operative management, review and obtain informed consent.The surgeon would also review the type of anesthesia with anesthesiologist, verify that all required instruments and supplies are available, and assist with draping and positioning the patient The surgeon would scrub and gown, and then perform the surgical "time out" with the operating and anesthesia team.

escription of Intra-Service Work: The anchoring site of the previous stimulator lead in the thoracolumbar spine is ocalized with the patient under anesthesia and the overlying soft tissue structures are anesthetized using local anesthesia to the level of the lamina. A midline incision is created and soft tissues dissected to expose the lead. Removal of scar tissue and additional bone around the prior laminectomy site, along with dissection of the epidural space are performed to access and remove the preexisting paddle lead in the epidural space via gentle traction. An image is obtained to document paddle lead removal. Removal of the implanted spinal neurostimulator pulse generator or receiver is a

separately reportable procedure (CPT 63688). The pre-existing paddle lead is disconnected from the connector to the electrodes of the pulse generator or receiver. The paddle lead is removed from the anchoring site. The incision is closed and dressings are applied.

Description of Post-Service Work: The patient is observed for stability of vital signs and comfort and then the opera communicates with the patient, family, and other health care professionals (including written and telephone reports and orders) and coordinates discharge day management. Additionally, all hospital visits and post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure. The surgeon would write prescriptions for medications needed after discharge and instructions, such as home restrictions (i.e., diet, activity, bathing, driving), are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge progress notes, discharge summary and discharge instructions, and insurance forms. The patient is discharged when there is return of adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation.
Office post-discharge work: Examine and talk with patient. Perform wound check. Remove sutures/staples if placed. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record. All post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009					
Presenter(s):	Fred Davis, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, Rodney Lee Jones, MD, Charles Mick, MD					
Specialty(s):	AAPM, AANS/CNS, ASA, ISIS, NASS					
CPT Code:	63662					
Sample Size:	1007	**Resp N:**	35	**Response:** 3.4 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	3.00	15.00
Survey RVW:		6.00	11.45	**12.50**	14.25	21.05
Pre-Service Evaluation Time:				**35.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		25.00	45.00	**60.00**	90.00	120.00
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	63662	**Recommended Physician Work RVU: 10.84**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**1.00**	**14.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**5.00**	**10.00**
Intra-Service Time:		**60.00**		
Immediate Post Service-Time:	**20.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
63030	090	13.03	**RUC Time**

CPT Descriptor Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44950	090	10.52	**RUC Time**	5033

CPT Descriptor 1 Appendectomy;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49650	090	6.30	**RUC Time**	19,242

CPT Descriptor 2 Laparoscopy, surgical; repair initial inguinal hernia

Other Reference CPT Code	Global	Work RVU	Time Source
62351	090	11.54	**RUC Time**

CPT Descriptor Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 37.1 %

TIME ESTIMATES (Median)	CPT Code: 63662	Key Reference CPT Code: 63030	Source of Time RUC Time
Median Pre-Service Time	63.00	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	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	69.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**243.00**	**342.00**
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	3.08
Urgency of medical decision making	2.31	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.38
Physical effort required	3.38	3.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.85	3.54
Outcome depends on the skill and judgment of physician	3.85	3.69
Estimated risk of malpractice suit with poor outcome	3.77	3.85

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.15
Intra-Service intensity/complexity	3.62	3.69
Post-Service intensity/complexity	2.85	2.92

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's Five Year Review Identification Workgroup has identified codes whose valuations include hospital inpatient and/or discharge services within their global period, but the site of service is no longer predominately in the

inpatient setting. One of these codes is 63660 – Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)

The RUC recommended that this code (along with the other codes in the family) be reassigned to a 10 day global peri and be re-surveyed. This has been done for codes 62350, 62355, 62360, 62361, 62362, 62365, 63650, 63685, and 63688. The multi-specialty expert panel convened to undertake the surveys determined that the current descriptor for code 63660 was too broad to be able to define the work and requested that the code go back to the CPT Editorial Panel with a proposal to split code 63660 into separate codes that will describe the distinct work involved in the revision and in the removal of a percutaneous electrode when compared to the revision or the removal of a "plate/paddle" electrode array. The result is four new codes. The two codes describing procedures on a percutaneous electrode have a 10 day global and the other two describing procedures on a plate/paddle electrode array maintain a 90 day global period and are performed in an in-patient setting.

The specialties determined that Pre-Service Package 2B with modifications to the positioning and scrub/dress/wait time was appropriate. Extra positioning time is required to turn an intubated patient into the prone position. There is additional wait time due to the time needed to induce anesthesia.

The median service performance rate for all respondents was zero. A supplemental summary is attached that shows the responses by the aggregate, by those who have not performed the service and by those who have.

The specialties came to their recommended RVUw of 10.19 (less than the 25th percentile) by comparing this service describing the removal of a spinal neurostimulator electrode plate/paddle that was placed via laminotomy or laminectomy with the recommendations for the code that describes its initial placement (63655). The recommended values for code 63655 yield an IWPUT of 0.070. Since the intraservice time for 63655 is 90 minutes and the intraservice time for 6366X2 is 60 minutes, we deducted that intensity from median survey value (RVU 12.50).

0.070 x 30 minutes = 2.1 RVUw

12.50 - 2.1 = 10.4

We then verified this value with a comparison to code 44950 – a code with similar times and an IWPUT of 0.078. Wi[redacted] our recommended times and RVUw, code 6366X2 will have an IWPUT of 0.086.

SERVICES REPORTED WITH MULTIPLE 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) Removal of the implanted spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63688)

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 63688 - global 010 - RVUw 5.25 - Pre-service 48" - Intra-service 55" - Post -service 20 " Included within the 10 day global period are 99238 x 0.5 and 99213 x 1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63660

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 Orthopedic Surgery	How often? Sometimes
Specialty Other	How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 810
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 7% of the cases previously reported with code 63660 would be reported with code 6366X2. We also estimate that the national frequency would be twice that of the Medicare population. Code 63660 was reported to Medicare 5,784 times in 2007 (5784 * .07 = 405. 405 * 2 = 810). Percentage breakdowns are taken from those for code 63655 - Laminotomy for implantation of neurostimulator electrodes, plate/paddle(s), epidural

Specialty Neurosurgery	Frequency 566	Percentage 69.87 %
Specialty Orthopedic Surgery	Frequency 198	Percentage 24.44 %
pecialty Other	Frequency 46	Percentage 5.67 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 405
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 7% of the cases previously reported with code 63660 would be reported with code 6366X2. Code 6366X2 was reported to Medicare 5,784 times in 2007 (5784 * .07 = 405

Specialty Neurosurgery	Frequency 283	Percentage 69.87 %
Specialty Orthopedic Surgery	Frequency 99	Percentage 24.44 %
Specialty Other	Frequency 23	Percentage 5.67 %

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.

dicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Surveyed Code : 63662
Surveyed Descriptor: Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
Surveyed Global: 90

Vignette used in survey: A 56 year old woman had a previous implantation of a plate/paddle dorsal column spinal stimulator for pain control with good coverage and control of pain in the affected area. Over time, the stimulator no longer provide coverage to the affected area despite revision and the plate/paddle is to be removed

	All responses		Svc Rate = 0		Svc Rate >0	
Percentage of survey respondents who found vignette to be typical:	97%		95%		100%	
Percent of survey respondents who stated they perform the procedure;						
In the hospital:	97%		95%		100%	
In the ASC:	3%		5%		0%	
In the office:	0%		0%		0%	
Percent of survey responded who stated they typically performed this procedure in the hospitial, stated that patient is;						
Discharged the same day:	38%		28%		50%	
Kept overnight (less than 24 hours).	53%		67%		38%	
Admitted (more than 24 hours:	9%		6%		13%	
Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day:	32%		31%		25%	
Is moderate sedation inherent to this procedure in the Hospital/ASC setting?	no		no		no	
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting:	54%		47%		63%	
Is moderate sedation inherent to this procedure in the office setting?	no		no		no	

1473

Percent of survey respondents who stated moderate sedation typical in the office setting:	11%		21%		0%			
Is moderate sedation inherent in your reference code (office setting)?	no		no		no			
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?	no		no		no			

SURVEY DATA

Specialty(s)			AAPM, AANS/CNS, ASA, ISIS, NASS					
Sample Size:	1007							
Resp N	35		19		16			
Response %	3.48%							
Service Performance Rate:	63662	Ref Svc 63030		63662	Ref Svc 62351		63662	Ref Svc 63030
Low	0	0		0	0		1	2.75
25th pctl	0	0		0	0		2	13.5
Median	0	0		0	0		4	26
75th pctl	3	13.5		0	0		6.25	26.25
High	15	100		0	50		15	100
Survey RVW:								
Low	6.00			6.50			6.00	
25th pctl	11.45			10.52			11.90	
Median	12.50			12.50			12.88	
75th pctl	14.25			13.10			14.68	
High	21.05			18.54			21.05	
Pre-Service Evaluation Time:								
Low	5			5			10	
25th pctl	25			30			20	
Median	35			35			35	
75th pctl	60			60			57.5	
High	140			120			110	
Pre-Service Positioning Time:								
Low	5			5			5	
25th pctl	10			10			10	
Median	15			15			15	
75th pctl	15			15			16.25	

1474

	High	30			20			30			
Pre-Service Scrub, Dress Wait Time:											
	Low	3			3			10			
	25th pctl	10			10			10			
	Median	15			10			15			
	75th pctl	17.5			15			20			
	High	30			30			30			
Intra-Service Time:											
	Low	25			25			30			
	25th pctl	45			45			56.25			
	Median	60			70			60			
	75th pctl	90			90			90			
	High	120			120			120			
Immediate Post Service Time:											
	Low	5			5			10			
	25th pctl	15			15			13.75			
	Median	20			20			17.5			
	75th pctl	22.5			22.5			21.25			
	High	60			60			45			
Modifier 51 Exempt: Y/N		no									
New Technology/Service: Y/N		no									
Key Reference Service:											
	CPT Code	63030				62351			63030		
	Descriptor	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar				Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar		
	Work RVU	13.03				11.54			13.03		
	Global	90				90			90		
	Time Source	RUC				RUC			RUC		
	Number of respondents who chose Key Reference Code	13				8			7		

1475

% of Respondents	37%				42%			44%	
TIME ESTIMATES (Median)	**Surveyed code**	**Key reference**	**Source of Time**		**Ref Svc (=0)**		**Ref Svc (>0)**		
	63662	63030	RUC		62351	RUC		63030	RUC
Median Pre-Service Time	63	75			62			75	
Median Intra-Service Time	60	90			90			90	
Median Immediate Post-Service Time	20	30			30			30	
Medican Critical Care Time									
Median Other Hospital Visit Time	20	40			165			40	
Median Discharge Day Mgmt Time	38	38			38			38	
Median Office Visit Time	62	69			64			69	
Prolonged Services Time									
Median Total Time	**263**	**342**			**449**			**342**	
Other time if appropriate									
INTENSITY/COMPLEXITY MEASURES (Mean)	63662	63030		63662	62351		63662	63030	
Mental Effort and Judgment (Mean)									
The number of possible diagnoses and/or the number of mgmt options that must be considered	3.00	3.00		3.00	3.13		3.00	2.57	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.08		3.25	3.13		2.86	2.57	
Urgency of medical decision making	2.31	3.00		2.75	2.75		2.14	3.00	
Technical Skill/Physical Effort (Mean)									
Technical skill required	3.54	3.38		3.63	3.50		3.29	3.00	
Physical effort required	3.38	3.23		3.38	3.13		3.29	3.00	
Psychological Stress (Mean)									
The risk of significant complications, mobidity and/or mortality	3.85	3.54		3.63	3.63		3.71	3.00	
Outcome depends on the skill and judgment of physician	3.85	3.69		3.63	3.63		3.71	3.29	
Estimated risk of malpractice suite with poor outcome	3.77	3.85		3.62	3.62		3.57	3.71	
Time Segments (Mean)									
Pre-Service intensity/complexity	3.00	3.15		3.13	2.88		3.00	3.00	
Intra-Service intensity/complexity	3.62	3.69		3.50	3.38		3.57	3.59	
Post-Service intensity/complexity	2.85	2.92		2.88	2.88		3.00	3.00	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63663 Tracking Number I3 Specialty Society Recommended RVU: **8.11**

Global Period: 010 RUC Recommended RVU: **7.70**

CPT Descriptor: Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54 year-old man had a previous implantation of a dorsal column spinal stimulator for pain control with good coverage and control of pain in the affected area. The patient suffered a fall, after which the stimulator no longer provided coverage to the affected area. The thoracic epidural stimulator array is to be repositioned to once again cover the affected area.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 71% , In the ASC 29%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 59% , Kept overnight (less than 24 hours) 38% , Admitted (more than 24 hours) 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform a E&M service later on the same day 53%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 60%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 27%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Communicating with the referring physician and other health care professionals, and obtaining informed consent. The physician would obtain and review the previous operative note(s) and any pertinent radiographs and medical information regarding implant from the implant manufacturer or available medical records. Pre-service work also includes a focused examination of the patient, pre-operative scrubbing and positioning, prepping, and draping the patient. The results of preadmission testing are reviewed. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. The physician would meet with patient and family to review planned procedure and post-operative management, review and obtain informed consent.The physician would also verify that all required instruments and supplies are available. The physician would also monitor/assist with draping and positioning of the patient. The physician would scrub and gown. A surgical "time out" is performed

Description of Intra-Service Work: The anchoring site of the previous stimulator lead in the thoracolumbar spine is localized and the overlying soft tissue structures are anesthetized to the level of the lamina. A midline incision is created and soft tissues dissected to expose the lead. The lead is cut at the site and removed from the epidural space via gentle traction. Using fluoroscopic guidance, a Touhy needled is advanced into the epidural space using a loss of resistance technique. Epidural location is confirmed with a percutaneous probe. A percutaneous electrode array is guided into the

epidural space through the needle and advanced toward the mid thoracic spine. The exposed end of the electrode array is attached to an external stimulator unit. Under guidance from the surgeon, a technician out of the operating field tests various electrode combinations and the lead(s) is/are physically relocated by the surgeon until the patient indicates that the dermatomal areas of his typical pain have been covered with paresthesias generated by the stimulator. The external unit is detached, the needle and stylet removed and the lead(s) is/are anchored to the fascia. Insertion or replacement of the implanted spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63685). The electrode array is attached to the neurostimulator pulse generator or receiver electrode connectors and anchored in place. An image is obtained to document final placement. The incision is closed and dressings are applied.

Description of Post-Service Work: The patient is observed for stability of vital signs and comfort and then the operator communicates with the patient, family, and other health care professionals (including written and telephone reports and orders) and coordinates discharge day management. Additionally, all hospital visits and post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure. The surgeon would write prescriptions for medications needed after discharge and instructions, such as home restrictions (i.e., diet, activity, bathing, driving), are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge progress notes, discharge summary and discharge instructions, and insurance forms. The patient is discharged when there is return of adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation.
Office post-discharge work: Examine and talk with patient. Perform wound check. Remove sutures/staples if placed. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record. All post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AANS/CNS, ASA, ISIS, NASS				
CPT Code:	63663				
Sample Size:	1007	**Resp N:**	52	**Response:** 5.1 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**4.00**	6.50	50.00
Survey RVW:	5.25	7.11	**8.11**	9.17	22.17
Pre-Service Evaluation Time:			**37.50**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	25.00	60.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	63663	**Recommended Physician Work RVU: 7.68**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
63650	010	7.15	**RUC Time**

CPT Descriptor Percutaneous implantation of neurostimulator electrode array, epidural

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38571	010	14.70	**RUC Time**	3,848

CPT Descriptor 1 Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20103	010	5.31	**RUC Time**	1,437

CPT Descriptor 2 Exploration of penetrating wound (separate procedure); extremity

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 61.5 %

TIME ESTIMATES (Median)	CPT Code: 63663	Key Reference CPT Code: 63650	Source of Time RUC Time
Median Pre-Service Time	48.00	48.00	
Median Intra-Service Time	90.00	60.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	23.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**200.00**	**170.00**	
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	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	3.50
Urgency of medical decision making	2.91	2.78

Technical Skill/Physical Effort (Mean)

Technical skill required	4.22	3.88
Physical effort required	3.72	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.94	3.59
Outcome depends on the skill and judgment of physician	4.31	4.06
Estimated risk of malpractice suit with poor outcome	3.81	3.66

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.44	3.22
Intra-Service intensity/complexity	4.16	3.75
Post-Service intensity/complexity	3.16	3.13

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.*

The RUC's Five Year Review Identification Workgroup has identified codes whose valuations include hospital inpatient and/or discharge services within their global period, but the site of service is no longer predominately in the inpatient setting. One of these codes is 63660 – Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)

The RUC recommended that this code (along with the other codes in the family) be reassigned to a 10 day global period and be re-surveyed. This has been done for codes 62350, 62355, 62360, 62361, 62362, 62365, 63650, 63685, and 63688. The multi-specialty expert panel convened to undertake the surveys determined that the current descriptor for code 63660 was too broad to be able to define the work and requested that the code go back to the CPT Editorial Panel with a proposal to split code 63660 into separate codes that will describe the distinct work involved in the revision and in the removal of a percutaneous electrode when compared to the revision or the removal of a "plate/paddle" electrode array. The result is four new codes. The two codes describing procedures on a percutaneous electrode have a 10 day global and the other two describing procedures on a plate/paddle electrode array maintain a 90 day global period and are performed in an in-patient setting.

The specialties determined that pre-service package 2B with modification was an appropriate package. The modification is identical to those approved for the reference service, namely, additional time for placing the patient into a prone position.

Physicians who perform these procedures agree that is easier to place a new array than to revise one. Removal of the existing lead can be difficult: the lead is often coiled and surrounded by scar tissue.

We compared the work associated with this service to the other codes in the family, including the key reference service 63650. The IWPUT for code 63650 is 0.069. Using median intra-and post –service times and adjusting the survey results downward to better reflect post-operative visits, the median RVUw of 8.11 yields an IWPUT of 0.057. These values place the code into proper alignment with the rest of the 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: 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) Insertion or replacement of the implanted spinal neurostimulator pulse generatior or receiver is separtely reported with code 63685

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 63685; global 010; RVUw 6.00; Pre-service 48"; Intra-service 60"; Post -service 20"; Included within the 10 day global period are 99238 x 0.5 and 99213 x 1

REQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63660

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Sometimes
Specialty Interventional Pain Mgmt/Pain Mgmt	How often? Sometimes
Specialty Neurosurgery	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 5784
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 50% of the cases previously reported with code 63660 would be reported with 6366X3. We also estimate that the national frequency would be twice that of the Medicare population. Code 63660 was reported to Medicare 5,784 times in 2007 Percentage breakdowns come from the RUC database.

Specialty Anesthesiology	Frequency 1854	Percentage 32.05 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 1848	Percentage 31.95 %
Specialty Neurosurgery	Frequency 1084	Percentage 18.74 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,892 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 50% of the cases previously reported with code 63660 would be reported with 6366X3. Code 63660 was reported to Medicare 5,784 times in 2007. (5784 * .50 = 2,892)

Specialty Anesthesiology	Frequency 927	Percentage 32.05 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 924	Percentage 31.95 %
Specialty Neurosurgery	Frequency 542	Percentage 18.74 %

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:63664 Tracking Number I4 Specialty Society Recommended RVU: **12.00**

Global Period: 090 RUC Recommended RVU: **11.39**

CPT Descriptor: Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56 year-old woman had a previous implantation of a dorsal column spinal stimulator for pian control with good coverage and control of pain in the affected area. The lead has fractured and the stimulator no longer provides coverage to the affected area. The plate/paddle electrode is to be removed and replaced to once again cover the affected area.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 19% , Kept overnight (less than 24 hours) 60% , Admitted (more than 24 hours) 21%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 46%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 38%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 16%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Communicating with the referring physician and other health care professionals, and obtaining informed consent. The physician would obtain and review the previous operative note(s) and any pertinent radiographs and medical information regarding implant from the implant manufacturer or available medical records. Pre-service work also includes a focused examination of the patient, pre-operative scrubbing and positioning, prepping, and draping the patient. The results of preadmission testing are reviewed. The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The preoperative history and physical examination is updated. Preoperative orders for antibiotics and sequential compression devices are written. The surgeon would meet with patient and family to review planned procedure and post-operative management, review and obtain informed consent.The surgeon would also review the type of anesthesia with anesthesiologist, verify that all required instruments and supplies are available, and assist with positioning the patient. The surgeon would also monitor/assist with draping and positioning of the patient. The surgeon would scrub and gown, and then perform the surgical "time out" with the operating and anesthesia team.

Description of Intra-Service Work: The anchoring site of the previous stimulator lead in the thoracolumbar spine is localized with the patient under anesthesia and the overlying soft tissue structures are anesthetized to the level of the lamina. A midline incision is created and soft tissues dissected to expose the lead. Scar tissue and additional bone removal around the prior laminectomy site, along with dissection of the epidural space are performed to access and

remove the preexisting paddle lead in the epidural space via gentle traction. A new paddle lead is placed through this laminectomy site using fluoroscopic guidance. The exposed end of the electrode array is attached to an external stimulator unit. Under guidance from the surgeon, a technician out of the operating field tests various electrode combinations and the lead is physically relocated by the surgeon until the patient indicates that the dermatomal areas her typical pain have been covered with paresthesias generated by the stimulator. Insertion or replacement of a implanted spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63685). The paddle lead is attached to the neurostimulator pulse generator or receiver electrode connectors. The lead is anchored to the fascia. An image is obtained to document final placement. The incision is closed and the sites dressed.

Description of Post-Service Work:
Post-service includes: The patient is observed for stability of vital signs and comfort and then the operator communicates with the patient, family, and other health care professionals (including written and telephone reports and orders) and coordinates discharge day management. Additionally, all hospital visits and post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure. The surgeon would write prescriptions for medications needed after discharge and instructions, such as home restrictions (i.e., diet, activity, bathing, driving), are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge progress notes, discharge summary and discharge instructions, and insurance forms. The patient is discharged when there is return of adequate nutrition intake, adequate pain control with oral analgesics, and independent ambulation.
Office post-discharge work: Examine and talk with patient. Perform wound check. Remove sutures/staples if placed. Review activity and restrictions. Perform neurological exam and confirm normal strength, reflexes and sensation. Answer patient/family questions. Write medication prescriptions. Order physiotherapy, as necessary, monitor rehabilitation. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record. All post-discharge office visits for care throughout the global period are considered part of the post-operative work for this procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009					
Presenter(s):	Fred Davis, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, Rodney Lee Jones, MD, Charles Mick, MD					
Specialty(s):	AAPM, AANS/CNS, ASA, ISIS, NASS					
CPT Code:	63664					
Sample Size:	1007	**Resp N:**	32	**Response:** 3.1 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	5.00	20.00
Survey RVW:		6.00	12.00	**13.75**	16.53	35.00
Pre-Service Evaluation Time:				**40.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		35.00	60.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	63664	**Recommended Physician Work RVU: 12.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**1.00**	**14.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**5.00**	**10.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
62351	090	11.54	**RUC Time**

CPT Descriptor Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63047	090	15.22	**RUC Time**	74,815

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60220	090	12.29	**RUC Time**	8,878

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU	Time Source
63030	090	13.03	**RUC Time**

CPT Descriptor Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 46.8 %

TIME ESTIMATES (Median)	CPT Code: 63664	Key Reference CPT Code: 62351	Source of Time RUC Time
Median Pre-Service Time	63.00	62.00	
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	0.0	165.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	64.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**273.00**	**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	3.00	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.20
Urgency of medical decision making	2.50	2.40

Technical Skill/Physical Effort (Mean)

Technical skill required	3.70	3.40
Physical effort required	3.50	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.30
Outcome depends on the skill and judgment of physician	3.70	3.60
Estimated risk of malpractice suit with poor outcome	3.30	3.30

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.40	3.10
Intra-Service intensity/complexity	3.60	3.40
Post-Service intensity/complexity	3.20	3.00

Additional Rationale

escribe 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's Five Year Review Identification Workgroup has identified codes whose valuations include hospital inpatient and/or discharge services within their global period, but the site of service is no longer predominately in the inpatient setting. One of these codes is 63660 – Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)

The RUC recommended that this code (along with the other codes in the family) be reassigned to a 10 day global period and be re-surveyed. This has been done for codes 62350, 62355, 62360, 62361, 62362, 62365, 63650, 63685, and 63688. The multi-specialty expert panel convened to undertake the surveys determined that the current descriptor for code 63660 was too broad to be able to define the work and requested that the code go back to the CPT Editorial Panel with a proposal to split code 63660 into separate codes that will describe the distinct work involved in the revision and in the removal of a percutaneous electrode when compared to the revision or the removal of a "plate/paddle" electrode array. The result is four new codes. The two codes describing procedures on a percutaneous electrode have a 10 day global and the other two describing procedures on a plate/paddle electrode array maintain a 90 day global period and are performed in an in-patient setting.

The specialties determined that Pre-Service package 2B with modification to the positioning and scrub/dress/wait time was appropriate. Extra positioning time is required as the patient is under anesthesia and prone. Wait time is increased as the level of anesthesia must be carefully titrated since the procedure requires a patient sufficiently sedated to tolerate the procedure yet sufficiently responsive to indicate that the dermatomal areas of her typical pain have been covered with paresthesias generated by the stimulator.

The median service performance rate for all respondents was zero. A supplemental summary is attached that shows the responses by the aggregate, by those who have not performed the service and by those who have.

This procedure is more complex than the reference service (62351) and 63655 although the surveyed times are the same as 63655. Code 6366X4 requires the surgeon to work on a previously operated field (previous laminotomy) and over the spinal cord, with accompanied increased risk for neurologic injury due to scarring from the earlier bony work. Tl intensity/complexity measures comparing 6366X4 with 62351 are consistent with this point as all but one are higher fo 6366X4. The recommendation is that the RUC accept an RVUwork value of 12.00 which is higher than 63655 but represents the 25 percentile of our survey respondents.

Code 6366X4 with the times and RVUw recommended by the specialties would have an IWPUT of 0.075.

SERVICES REPORTED WITH MULTIPLE 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) Insertion or replacement of the implanted spinal neurostimulator pulse generator or receiver is a separately reportable procedure (CPT 63685)

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 63685; global 010; Pre-service 48"; Intra-service 60"; Post -service 20"; Included within the 10 day global period are 99238 x 0.5 and 99213 x 1

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63660

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 Orthopedic Surgery	How often? Sometimes
Specialty Other	How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1156
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 10% of the cases previously reported with code 63660 would be reported with 6366X4. We also estimate that the national frequency would be twice that of the Medicare population. Code 63660 was reported to Medicare 5,784 times in 2007. (5784 * .10 = 578. 578 * 2 = 1156)
Percentage breakdowns are taken from those for code 63655 - Laminotomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Specialty Neurosurgery	Frequency 809	Percentage 69.98 %
Specialty Orthopedic Surgery	Frequency 283	Percentage 24.48 %
Specialty Other	Frequency 65	Percentage 5.62 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 578
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 10% of the cases previously reported with code 63660 would be reported with 6366X4. Code 6366X4 was reported to Medicare 5,784 times in 2007. (5784 8 * .10 = 578)

Specialty Neurosurgery	Frequency 404	Percentage 69.89 %
Specialty Orthopedic Surgery	Frequency 141	Percentage 24.39 %
Specialty Other	Frequency 33	Percentage 5.70 %

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

Surveyed Code : 63664

Surveyed Descriptor: Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) place via laminotomy or laminectomy, including fluoroscopy, when performed

Surveyed Global: 90

Vignette used in survey: A 56 year old woman had a previous implantation of a dorsal column spinal stimulator for pain control with good coverage and control of pain in the affected area. The lead has fractured and the stimulator no longer provided coverage to the affected area.The thoracic epidural stimulator array is to be removed and replaced to once again cover the affected area

	All Responses		Svc rate =0		Svc rate >0	
Percentage of survey respondents who found vignette to be typical:	88%		94%		80%	
Percent of survey respondents who stated they perform the procedure;						
In the hospital:	100%		100%		100%	
In the ASC:	0%		0%		0%	
In the office:	0%		0%		0%	
Percent of survey responded who stated they typically performed this procedure in the hospitial, stated that patient is;						
Discharged the same day:	19%		24%		13%	
Kept overnight (less than 24 hours):	90%		59%		60%	
Admitted (more than 24 hours:	21%		18%		27%	
Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day:	46%		54%		38%	
Is moderate sedation inherent to this procedure in the Hospital/ASC setting?	no		no		no	
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting:	38%		35.29%		40.00%	
Is moderate sedation inherent to this procedure in the office setting?	no		no		no	

1491

Percent of survey respondents who stated moderate sedation typical in the office setting:	16%		29%		0%			
Is moderate sedation inherent in your reference code (office setting)?	no		no		no			
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?	no		no		no			

SURVEY DATA

Specialty(s): AAPM, AANS/CNS, ASA, ISIS, NASS

Sample Size:	1007			17			15		
Resp N	32								
Response %	3.18%								
Service Performance Rate:	63664	Ref svc 62351		63664	Ref svc 62351		63664	Ref svc 63047	
Low	0	0		0	0		1	0	
25th pctl	0	0		0	0		4	4	
Median	0	0.5		0	0		5	10	
75th pctl	5	7		0	0		8	20	
High	20	50		0	1		20	50	
Survey RVW:									
Low	6.00			9.25			6.00		
25th pctl	12.00			11.80			14.50		
Median	13.75			12.50			16.00		
75th pctl	16.53			13.50			20.25		
High	35.00			19.54			35.00		
Pre-Service Evaluation Time:									
Low	10			10			10		
25th pctl	30			30			32		
Median	40			35			50		
75th pctl	60			50			60		
High	140			120			105		
Pre-Service Positioning Time:									
Low	5			5			10		
25th pctl	10			10			15		
Median	15			15			15		
75th pctl	15			15			20		

1492

High	30			20			30		
Pre-Service Scrub, Dress Wait Time:									
Low	5			5			10		
25th pctl	10			10			10		
Median	15			15			15		
75th pctl	15			15			20		
High	30			30			25		
Intra-Service Time:									
Low	35			35			45		
25th pctl	60			60			67.5		
Median	90			90			90		
75th pctl	120			90			120		
High	180			180			180		
Immediate Post Service Time:									
Low	10			10			10		
25th pctl	15			15			20		
Median	20			15			20		
75th pctl	30			20			30		
High	60			60			45		
Key Reference Service:									
CPT Code	62351			62351			63047		
Descriptor	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy			Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy			Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar		
Work RVU	11.54			11.54			15.22		
Global	90			90			90		
Time Source	RUC			RUC			RUC		
Number of respondents who chose Key Reference Code:	15			7			4		
% of Respondents	42%			41%			26%		

1493

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

63661: Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

63663: Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, 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 consisting of RUC and CPT and health policy representatives of the North American Spine Society (NASS), the International Spine Intervention Society (ISIS), the American Academy of Pain Medicine (AAPM), the American Society of Anesthesiologists (ASA), the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS) was convened to review the practice expense inputs for the new codes shown above. The panel included physicians in solo practice, academic settings, and large group practices and represented a multitude of geographic locations.

.ease describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. They arrange with the stimulator manufacturer for appropriate implants/supplies to be available. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carried out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Discharge management and standard office visit related activities are performed.

CPT Code:63661, 63663

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Non Facility Direct Inputs

CPT Long Descriptor:

63661: Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

63663: Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, 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 consisting of RUC and CPT and health policy representatives of the North American Spine Society (NASS), the International Spine Intervention Society (ISIS), the American Academy of Pain Medicine (AAPM), the American Society of Anesthesiologists (ASA), the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS) was convened to review the practice expense inputs for the new codes shown above. The panel included physicians in solo practice, academic settings, and large group practices and represented a multitude of geographic locations.

Discussion

The consensus panel discussed the site of service for these two codes and believes both can safely be performed in an office or radiology suite. The survey respondents however felt that this location was rare (3% for 63661 and 0% for 63663). The practice patterns vary in different geographic regions and the panel is aware of physicians who perform these procedures in the non-facility setting. We have priced these two procedures for both facility and non-facility.

Both of these procedures require fluoroscopy. Currently a licensed radiation therapist is typically required by law in many states to operate the fluoroscopy machine. A second clinical assistant (staff blend RN/LPN/MA) is required to assist the physician performing the procedure.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. They schedule space and equipment needed and arrange with the stimulator manufacturer for appropriate implants/supplies to be available. Clinical staff will provide and review educational materials and information prior to the procedure. In the office setting we moved the pre-service education from the pre-service period to the service period and decreased the time for this activity from 7 minutes to 3 minutes. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure

The RT obtains and displays the previous images.

Intra-Service Clinical Labor Activities:

Clinical staff reviews the chart to be certain all pre-procedure testing is available and the medical history is current. The patient will be greeted and gowned and four vital signs obtained. The procedure is reviewed. The procedure room is prepared, making certain supplies and equipment necessary are available. Clinical staff assists the physician with prepping, positioning, and providing anesthesia. This is a sterile procedure therefore, once the clinical staff is gloved, they will remain in the room and assist the physician with the entire procedure. After completion of the procedure, clinical staff will monitor the patient. The panel estimates the patient is monitored 20 minutes for 63661 and 40 minutes for 63663. We allocated ¼ of this time (5 minutes and 10 minutes respectively) to staff to allow for multi-tasking. Staff will clean the room; clean the surgical instruments; check dressings; and provide instructions on wound care, follow-up visits, and prescriptions.

RT prepares the imaging equipment and inputs patient and procedure information. They position the C-arm and assist in final positioning of the patient and obtain scout films. They perform imaging as required during the procedure. At the end of the procedure, they clean the equipment and process and store hard copies of films.

Post-Service Clinical Labor Activities:

Discharge management, phone calls and standard office visit related activities are performed.

CPT Code:63655, 63662, 63664

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

63655: Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

63662: Removal of neurostimulator electrode plate/paddle(s) placed via laminotomy or Laminectomy, including fluoroscopy, when performed

63664: Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or Laminectomy, including fluoroscopy, 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 consisting of RUC and CPT and health policy representatives of the North American Spine Society (NASS), the International Spine Intervention Society (ISIS), the American Academy of Pain Medicine (AAPM) the American Society of Anesthesiologists (ASA), the American Association of Neurological Surgeons (AANS), and the Congress of Neurological Surgeons (CNS) was convened to review the practice expense inputs for the codes shown above. The panel included physicians in solo practice, academic settings, and large group practices and represented a multitude of geographic locations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. They arrange with the stimulator manufacturer for appropriate implants to be available. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carrier out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Discharge management (standard 6 minutes for same day or 12 minutes for overnight/admit) and standard office visit related activities are performed.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				63661		63663		63662		63664		63655	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed		Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed		Removal of neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed		Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed		Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			10	10	10	10	90	90	90	90	90	90
5	TOTAL CLINICAL LABOR TIME			168.5	66.0	229.0	66.0	0.0	159.0	0.0	159.0	0.0	159.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			6.0	30.0	9.0	30.0	0.0	60.0	0.0	60.0	0.0	60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			123.5	0.0	181.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			39.0	36.0	39.0	36.0	0.0	99.0	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/MA	3	5	3	5		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MA	0	10	3	10		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MA	0	5	0	5		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	0	7	0	7		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA	3	3	3	3		7		7		7
16	Other Clinical Activity (please specify)- Pull & hang prior imaging studies for MD to review	L041B	RT	0	0	0	0		0		0		0
17	End: When patient enters office/facility for surgery/procedure												
18	SERVICE PERIOD												
19	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure												
20	Review charts	L037D	RN/LPN/MA	2		2							
21	Greet patient and provide gowning	L037D	RN/LPN/MA	3		3							
22	Obtain vital signs	L037D	RN/LPN/MA	5		5							
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	3		3							
24	Prepare room, equipment, supplies	L037D	RN/LPN/MA	3		3							
25	Prepare room, equipment, supplies	L041B	RT	3		3							
26	Setup scope (non facility setting only)	L037D	RN/LPN/MA										
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	3		3							
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	3		3							
29	Sedate/apply anesthesia												
30	Intra-service												
31	Assist physician in performing procedure	L037D	RN/LPN/MA	55		90							
32	Assist physician in performing procedure	L041B	RT	27.5		45							
33	Post-Service												
34	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA	5		10							
35	Clean room/equipment by physician staff	L037D	RN/LPN/MA	3		3							
36	Clean room/equipment by physician staff	L041B	RT	3		3							
37	Clean Scope												
38	Clean Surgical Instrument Package												
39	Complete diagnostic forms, lab & X-ray requisitions												
40	Review/read X-ray, lab, and pathology reports												
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MA	3		3							
42	Discharge day management												
43	Other Clinical Activity (please specify)- Process, hang, file films and review studies with interpreting MD	L041B	RT	2		2							
44	End: Patient leaves office												
45	POST SERVICE Period												
46	Start: Patient leaves office/facility												
47	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MA	3		3							
48	*Office visits:*												
49	*List Number and Level of Office Visits*												

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				63661		63663		63662		63664		63655	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed		Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed		Removal of neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed		Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed		Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
50	99211 16 minutes		16										
51	99212 27 minutes		27						1		1		1
52	99213 36 minutes		36	1	1	1	1		2		2		2
53	99214 53 minutes		53										
54	99215 63 minutes		63										
55	Other: 99231												
56	99238	L037D	RN/LPN/MA		0.5		0.5		1		1		1
57	*Total Office Visit Time*	L037D	RN/LPN/MA	36	36	36	36	0	99	0	99	0	99
58	Other Activity (please specify)												
59	End: with last office visit before end of global period												

1505

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				63661		63663		63662		63664		63655	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed		Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed		Removal of neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed		Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed		Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
60	MEDICAL SUPPLIES	CMS Code	Unit										
61	pack, minimum multi-specialty visit	SA048	item	2	1	2	1		3		3		3
62	pack, basic injection	SA041	item	1		1							
63	cautery, monopolar, pencil-handpiece	SF020	item	1		1							
64	cautery, patient ground pad w cord	SF021	item	1		1							
65	scalpel with blade, surgical (#10-20)	SF033	item	1		1							
66	suture, nylon, 3-0 to 6-0,c	SF036	item	1		1							
67	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item	1		1							
68	drape, sterile, three-quarter sheet	SB014	item	1		1							
69	drape-cover, sterile, OR light handle	SB016	item	1		1							
70	shoe covers, surgical	SB039	item	1		1							
71	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1							
72	suction canister	SD009	item	1		1							
73	scrub brush (impregnated)	SM023	item	1		1							
74	pack, cleaning surgical instruments	SA043	item	1		1							
75	pack, post-op incision care (suture)	SA054	item	1		1			1		1		1
76	bandage, Klign, non-sterile 2in	SG017	item										
77	EQUIPMENT	CMS Code	Unit										
78	stretcher	EF018	item	21		26							
79	room, radiographic-fluoroscopic	EL014		64		99							
80	x-ray view box, 4 panel	ER067		64		99							
81	printer, dye sublimation (photo, color)	ED031		64		99							
82	basic surgical instrument package	EQ137		64		99							
83	electrocautery	EQ110		64		99							
84	light, surgical	EF014		64		99							
85	exam table	EF023		0		0			1		1		1

1506

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five-Year Review

April 2009

Injection of Anesthetic Agent

The RUC identified these services through its High Volume Growth screen and referred the services to CPT to devise an appropriate coding structure to report primary and additional injections. Additionally, several other services within the same family were identified through the CMS Fastest Growing Procedures screen and were recommended to be surveyed by the RUC (64415, 64445, 64447), while services that were identified through the RUC screen (64470, 64472, 64475, 64476) were recommended to be referred to CPT prior to review by the RUC. In response to the RUC's request, the CPT Editorial Panel deleted the four existing codes describing injection of anesthetic agent (64470, 64472, 64475, 64476) and replaced them with six new services. Three codes describe the work performed in injection within the cervical or thoracic area in a single injection, second injection, and all further injections and the other three codes describe the work performed in injection within the lumbar or sacral area in a single injection, second injection and all further injections.

1508

64490, ***Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level***

The specialty society presented the survey results of 116 physicians. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64470, includes 20 minutes of intra-service time. The survey median work RVU was 2.00. However, the specialty noted that the key reference service selected by the respondents was 62310, *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; cervical or thoracic* (work RVU = 1.91, intra-service time = 30 minutes). The specialty noted that the reference service does not include any fluoroscopic guidance, and that there are no other 000 global codes that describe both injection and image guidance. The RUC did not agree that the pre-service evaluation time presented by the specialties was appropriate. Rather, the RUC agreed that pre-service time package number 5, NF procedure without sedation/anesthesia, which allots 7 minutes for evaluation, was all that was required. The RUC understands that Evaluation and Management (E/M) services may be reported on the same date as these injections. Therefore, the RUC removed the additional 8 minutes from the specialty's recommendation and backed-out the associated work per minute (0.0224 x 7 = 0.18) from the survey median work RVU of 2.00, to arrive at a work RVU of 1.82 (2.00 – 0.18 = 1.82). The RUC also reviewed reference code 36569, *Insertion of peripherally inserted*

central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older (work RVU = 1.82, intra-time = 20 minutes) and agreed that the two services are similar. **Therefore, the RUC recommends a work RVU of 1.82 for CPT code 64490.**

64491, *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level*

The specialty society presented the survey results of 80 physicians for this ZZZ add-on code. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64472, includes 20 minutes of intra-service time. Further, the RUC noted that the base code, 64490 also contains 15 minutes of intra-services time. However, the survey respondents indicated 10 minutes of pre-service and 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. Eighty percent of the survey respondents selected 64627, *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.16, intra-service = 30 minutes) as the key reference service. While the intra-service times are different between the survey code and the reference code (15 and 30 minutes, respectively), the RUC agreed that the two services are very similar. However, the reference service does not contain any imaging guidance. Further, the survey median work RVU was 1.16, which the RUC agreed was appropriate and maintains the rank and relationship between the base code and the add-on procedure. **Therefore, the RUC recommends a work RVU of 1.16 with an intra-service time of 15 minutes for 64491.**

64492, *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)*

The specialty society presented the survey results of 75 physicians for this ZZZ add-on code. The median survey intra-service time was 13 minutes, which the specialty noted was inconsistent with the survey results for 64491. The specialty societies' expert panel recommended and the RUC agreed that the intra-service time for 644X2 should be identical to 64491. Therefore, the RUC agreed that 15 minutes was appropriate. Further, the RUC noted that the base code, 64490 also contains 15 minutes of intra-services time. However, the survey respondents indicated 5 minutes of pre-service and 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. Eighty percent of the survey respondents selected 64627, *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.16, intra-service = 30 minutes) as the key reference service. While the intra-service times are different between the survey code and the reference code (15 and 30 minutes, respectively), the RUC agreed that the two services are very similar. However, the reference service does not contain any imaging guidance. Further, the survey median work RVU was 1.10, which the RUC did not agree maintained the rank and relationship between the base code and the add-on procedure. Rather, the RUC agreed that the typical work of 64492 is identical to 64491 and should be valued identically. The RUC also reviewed reference code 36584, *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump,*

through same venous access (work RVU = 1.20, intra-time = 15 minutes) and agreed that the two services are similar. **Therefore, the RUC recommends a work RVU of 1.16 with an intra-service time of 15 minutes for 64492.**

64493, *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level*

The specialty society presented the survey results of 88 physicians. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64470, includes 20 minutes of intra-service time. The survey median work RVU was 1.70. However, the specialty noted that the key reference service selected by the respondents was 27096, *Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid* (work RVU = 1.40, intra-service time = 25 minutes). The specialty noted that the reference service does not include any fluoroscopic guidance, and that there are no other 000 global codes that describe both injection and image guidance. The RUC did not agree that the pre-service evaluation time presented by the specialties was appropriate. Rather, the RUC agreed that pre-service time package number 5, NF procedure without sedation/anesthesia, which allots 7 minutes for evaluation, was all that was required. The RUC understands that Evaluation and Management (E/M) services may be reported on the same date as these injections. Therefore, the RUC removed the additional 8 minutes from the specialty's recommendation and backed-out the associated work per minute (0.0224 x 7 = 0.18) from the survey median work RVU of 1.70, to arrive at a work RVU of 1.52 (1.70 – 0.18 = 1.52). The RUC also review reference code, 95865, *Needle electromyography; larynx* (work RVU = 1.57, intra-time = 15 minutes) and agreed that the two services are similar. **Therefore, the RUC recommends a work RVU of 1.52 for CPT code 64493.**

1510

64494, *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level*

The specialty society presented the survey results of 70 physicians for this ZZZ add-on code. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64475, includes 18 minutes of intra-service time. Further, the RUC noted that the base code, 64493 also contains 15 minutes of intra-services time. However, the survey respondents indicated 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. Nearly 80% of the survey respondents selected 64623, *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 0.99, intra-service = 16 minutes) as the key reference service. The RUC agreed that the two services are very similar with very similar intra-service times. However, the reference service does not contain any imaging guidance, which justifies a slightly higher work RVU for the surveyed code. The median survey work RVU was 1.10, which the RUC agreed was too high. However, the survey 25th percentile work RVU of 0.98 would create a rank order anomaly with the reference service. The specialty societies' expert panel recommended and the RUC agreed that 1.00 was appropriate and maintains the rank and relationship between the base code and the

add-on procedure. The RUC also noted that the survey median work RVU of 64495 was 1.00. **Therefore, the RUC recommends a work RVU of 1.00 with an intra-service time of 15 minutes for 64494.**

64495, *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)*
The specialty society presented the survey results of 64 physicians for this ZZZ add-on code. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, considering that the existing service, 64475descriptor, includes 18 minutes of intra-service time. Further, the RUC noted that the base code, 64494 also contains 15 minutes of intra-services time. However, the survey respondents indicated 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. More than 80% of the survey respondents selected 64623, *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 0.99, intra-service = 16 minutes) as the key reference service. The RUC agreed that the two services are very similar with very similar intra-service times. However, the reference service does not contain any imaging guidance, which justifies a slightly higher work RVU for the surveyed code. The median survey work RVU was 1.00, which the RUC agreed was appropriate and maintains the rank and relationship between the base code and the add-on procedure. **Therefore, the RUC recommends a work RVU of 1.00 with an intra-service time of 15 minutes for 64495.**

Practice Expense
The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

Work Neutrality
The specialty society provided data to the RUC showing that the new coding structure will account for an overall decrease in work relative values for this family of services to be redistributed in the Medicare conversion factor. 64470, 64472, 64475, and 64476 were reported as follows in 2007, accounting for 1,929,084 work RVUs.

Code	Work RVU	2007 Frequency	Total work RVUs
64470	1.80	133,092	239,566
64472	1.29	215,038	277,399
64475	1.41	485,428	684,453
64476	0.98	742,516	727,666
Total work RVUs			**1,929,084**

The specialty society estimates that the new services will be reported as follows, which results in a reduction of 600,422 work RVUs.

Code	Work RVU	2007 Frequency	Total work RVUs
64490	1.82	133,092	242,227
64491	1.16	119,783	138,948
64492	1.16	35,935	41,685
64493	1.52	485,428	737,851
64494	1.00	36,885	36,885
64495	1.00	131,066	131,066
Total work RVUs			**1,328,662**

1512

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681) (For epidural or subarachnoid or subdural injection, see 62310-62319) (Codes 6449064484 are unilateral procedures. For bilateral procedures, use modifier 50) (For fluoroscopic guidance and localization for needle placement and injection in conjunction with 64479-64484, use 77003)				
64415		Injection, anesthetic agent; brachial plexus, single	000	To be presented at October 2009 RUC Meeting
64445		sciatic nerve, single	000	To be presented at October 2009 RUC Meeting

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
64447		femoral nerve, single	000	To be presented at October 2009 RUC Meeting
64450		other peripheral nerve or branch ~~(For phenol destruction, see 64622-64627)~~ ~~(For subarachnoid or subdural injection, see 62280, 62310-62319)~~ ~~(For epidural or caudal injection, see 62273, 62281-62282, 62310-62319)~~ ~~(For injection of Morton's neuroma, see 64455, 64632)~~	000	1.27 (No Change)
64455		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma) (Do not report 64455 in conjunction with 64632) (Codes 64470-64484 are unilateral procedures. For bilateral procedures, use modifier 50) ~~(For fluoroscopic guidance and localization for needle placement and injection in conjunction with 64470-64484, use 77003)~~	000	0.75 (No Change)
D 64470		~~Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level~~	000	N/A
D +64472		~~cervical or thoracic, each additional level (List separately in addition to code for primary procedure)~~	ZZZ	N/A
D 64475		~~lumbar or sacral, single level~~	000	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D +64476		~~lumbar or sacral, each additional level, (List separately in addition to code for primary procedure)~~ ~~(Use 64476 in conjunction with 64475)~~ (Codes 64470–64476 have been deleted. To report, see 64490–64495)	ZZZ	N/A
Paravertebral Spinal Nerves and Branches (Image guidance (fluoroscopy or CT) and the injection of contrast are inclusive components of codes 64490-64493. Imaging guidance and localization are required for the performance of 64490-64493. If imaging is not used, report code 20550-20553. If ultrasound guidance is used, report 64999) (For bilateral procedures, use modifier 50) (For injection of the T12-L1 joint, or nerves innervating that joint, report code 64492)				
•64490	EE1	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	000	1.82
•+64491	EE2	second level (List separately in addition to code for primary procedure)	ZZZ	1.16
•+64492	EE3	third and any additional level(s) (List separately in addition to code for primary procedure) (Do not report 64492 more than once per day) (Use 64491 and 64492 in conjunction with 64490)	ZZZ	1.16

1514

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●64493	000	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	000	1.52
●+64494	EE5	second level (List separately in addition to code for primary procedure)	ZZZ	1.00
●+64495	EE6	third and any additional level(s) (List separately in addition to code for primary procedure) (Do not report 64495 more than once per day) (Use 64494 and 64495 in conjunction with 64493)	ZZZ	1.00
E 77003		Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, ~~paravertebral facet joint, paravertebral facet joint nerve~~, or sacroiliac joint), including neurolytic agent destruction *(Injection of contrast during fluoroscopic . . .)* (For paravertebral facet joint injection, see ~~64470-64476~~64490-64495) *(For destruction by neurolytic agent, see . . .)*	XXX	0.60 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64490 Tracking Number EE1 Specialty Society Recommended RVU: **2.00**

Global Period: 000 RUC Recommended RVU: **1.82**

CPT Descriptor: Injection(s), diagnostic or therapeutic agent, paravertebrel facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female has chronic neck pain radiating toward her right shoulder. Previously performed assessments, tests and therapeutic trials have demonstrated the following: She has no neurological symptoms or weakness in her arms. Physical examination revealed restricted range of motion of her cervical spine due to pain. She has pain with palpation of her cervical spine and extension of her neck. These findings are consistent with facet pain at the C4-5 level. X-rays demonstrate facet arthopathy and spondylosis at C4-5. The patient has failed conservative treatments, including physical therapy, nonsteroidal anti-inflammatory medications, and opiate therapy with persistent pain and limitations in function. An MRI demonstrated facet arthropathy at C4-5 and multilevel degenerative disc disease. An electromyogram was negative for radiculopathy. Due to her failure with conservative treatment and persistent pain, diagnostic testing with cervical facet blocks under fluoroscopic guidance on the right at the C4-5 level is indicated. This will be performed by blocking the right C4 and C5 medial branch nerves that innervate the C4-5 facet joint.
(Imaging guidance (fluoroscopy or CT) is included in this code.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 46%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 23%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Medical records and relevant history were reviewed with the patient, informed consent obtained, and documentation completed. The patient was taken to the fluoroscopy suite for medial branch blocks to the right C4-5 facet joint. The patient was placed on a radiolucent carbon-fiber table, prepped and draped in the usual fashion.

Description of Intra-Service Work: The patient was monitored with continuous pulse oximetry, blood pressure and ECG. A C-arm fluoroscopy machine was rotated and adjusted until the targeted facet joint and the bony landmarks corresponding to the right C4 and C5 medial branch nerves (that innervate the right C4-5 facet joint) were optimally visualized. Initially, the C4 medial branch nerve was targeted. The skin and sub-cutaneous tissues were anesthetized

with 1cc of 1% lidocaine. Then a 25-gauge 2.5-inch needle was directed towards the lateral facet pillar and groove under intermittent fluoroscopic guidance. Care was taken to avoid vital neural structures or blood vessels. Appropriate positioning of the needle tip was confirmed with multiple fluoroscopic views, including A-P and lateral projections. Approximately 0.3 cc of non-ionic contrast was injected to confirm appropriate spread around the targeted nerve exclude any vascular, epidural or intrathecal spread. Then 0.3 cc of 2 % Xylocaine MPF was slowly infiltrated aro the C4 medial branch nerve, after which the needle was removed. With the patient still prepped and draped, the fluoroscopic machine was re-oriented inferiorly and the entire procedure repeated to block the C5 medial branch nerve. Thereafter, a bandage was applied and the patient was taken to the recovery area

Description of Post-Service Work: The patient was monitored for an appropriate period of time prior to being discharged to home. Patient was examined and pain levels assessed prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, William Sullivan, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, William Donovan, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AAPMR, AANS/CNS, ASA, ASNR, ISIS, NASS				
CPT Code:	64490				
Sample Size:	1847	**Resp N:**	116	**Response:** 6.2 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**50.00**	120.00	1000.00
Survey RVW:	1.25	1.89	**2.00**	2.20	8.30
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	4.00	15.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64490	**Recommended Physician Work RVU: 1.82**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**0.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**0.00**	**5.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62310	000	1.91	**RUC Time**

CPT Descriptor 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; cervical or thoracic

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52000	000	2.23	**RUC Time**	948,337

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64449	000	1.81	**RUC Time**	3,774

CPT Descriptor 2 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 63 **% of respondents:** 54.3 %

TIME ESTIMATES (Median)	**CPT Code: 64490**	**Key Reference CPT Code: 62310**	**Source of Time RUC Time**
Median Pre-Service Time	17.00	35.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**42.00**	**85.00**
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	3.62	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.68
Urgency of medical decision making	2.76	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.32	4.14
Physical effort required	3.41	3.32

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.11	4.10
Outcome depends on the skill and judgment of physician	4.25	4.17
Estimated risk of malpractice suit with poor outcome	4.06	4.08

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.03	3.00
Intra-Service intensity/complexity	3.84	3.76
Post-Service intensity/complexity	2.89	2.84

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an INPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialties determined that Pre-service package 5 with some modification was the best fit for this procedure. The evaluation time was increased by 8 minutes to account for the thoroughness of the exam, the large number of records and imaging studies that must be reviewed and the time it takes to explain the procedure to the patient. Cervical facet

injections are typically performed with the patient in the prone position and that requires 5 minutes of positioning time. These procedures are performed under sterile conditions requiring 5 minutes of scrub/dress/wait time.

It appears that our survey participants may not have fully understood that they were to include the work associated v fluoroscopy (or CT) in their responses. There are no other zero day global codes that include imaging guidance so were unable to provide an example in our Reference Service List. Fluoroscopic guidance (code 77003) has a work RVU of 0.60. If this were added to the value of the current code (64470 with 1.85 RVUw) the result with be 2.45 RVUw. We are recommending the survey median of 2.00 which we believe understates the work; subtracting fluoroscopy means that the work of the injection is captured by the remaining 1.40 RVUw commensurate to an SI injection (code 27096) and well below that of the reference service. The risks of a cervical facet injection include, but are not limited to: potential seizures from placement of anesthetic in the vertebral artery, nerve root damage and quadriplegia from injection into the nerve roots or spinal cord.

A work RVUw of 2.00 somewhat aligns with the work differential between cervical/thoracic and lumbar/sacral injections which is typically 0.37 - 0.44 (example: the tranlaminar epidural codes 62310 and 62311 (1.91-1.54 = 0.37). Our recommendation for code 64490 is validated by the survey median of 1.70 for code 64493 (Injection(s) diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code could could be reported on its own or in conjunction with +64XX1 - an add-on code to describe the second level and +64XX2 - an add-on code to describe the third and any level(s).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64470

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Pain Mgmt/Pain Mgmt — How often? Commonly

Specialty Anesthesiology — How often? Commonly

Specialty Physical Medicine & Rehabilitation How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 266184
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the national figure would be twice the Medicare frequency. Per the RUC database, the 2007 frequency for code 64470 as 133,092. Percentages come from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 79376	Percentage 29.81 %
Specialty Anesthesiology	Frequency 68596	Percentage 25.77 %
Specialty Physical Medicine & Rehabilitation	Frequency 29467	Percentage 11.07 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 133,092 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2007 Frequency per RUC data base was 133,092. Percentages also from RUC database

Specialty Interventional Pain Mgmg/Pain Mgmt	Frequency 39688	Percentage 29.81 %
Specialty Anesthesiology	Frequency 34298	Percentage 25.77 %
Specialty Physical Medicine & Rehabilitation	Frequency 14733	Percentage 11.06 %

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:64491 Tracking Number EE2 Specialty Society Recommended RVU: **1.16**

Global Period: ZZZ RUC Recommended RVU: **1.16**

CPT Descriptor: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old female has chronic neck pain radiating toward her right shoulder. Previously performed assessments, tests and therapeutic trials have demonstrted the following: She has no neurological symptoms or weakness in her arms. Physical examination revealed restricted range of motion of her cervical spine due to pain. She has pain with palpation of her cervical spine and extension of her neck. These findings are consistent with facet pain at the C4-C5 and C5-6 levels. X-rays demonstrated facet arthropathy and spondylosis at C4-C5 and C5-6. The patient has failed conservative treatments including physical therapy, nonsteroidal anti-inflammatory medications, opiate therapy with persistent pain and limitations in function. An MRI demonstrated facet arthropathy at C4-C5 and C5-6 along with multilevel degenerative disc disease. An electromyogram was negative for radiculopathy. Due to her failure with conservative treatment and persistent pain, diagnostic testing with cervical facet blocks under fluoroscopic guidance on the right at the C4-C5 and C5-6 levels is indicated. This will be performed by blocking the right C4, C5 and C6 medial branch nerves that innervate the C4-C5 and C5-6 facet joints.
(Imaging guidance (fluoroscopy or CT) is included in this code.)
(Code 64XXT includes only the work associated with injection of the second level.)

64491

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 42%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 25%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: After injections are placed at the C4-5 joint's medial branch nerves, and with the patient still prepped and draped, the fluoroscopic machine was re-oriented inferiorly and the entire procedure was repeated to block the C5-6 joint's medial branch nerves

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, William Sullivan, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, William Donovan, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AAPMR, AANS.CNS. ASA, ASNR, ISIS, NASS				
CPT Code:	64491				
Sample Size:	1847	**Resp N:**	80	**Response:** 4.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	9.00	**50.00**	100.00	1000.00
Survey RVW:	0.40	4.00	**1.16**	1.50	5.25
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	10.00	**15.00**	20.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64491	**Recommended Physician Work RVU: 1.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64627	ZZZ	1.16	**RUC Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	13,490

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

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
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 64 **% of respondents:** 80.0 %

TIME ESTIMATES (Median)	**CPT Code: 64491**	**Key Reference CPT Code: 64627**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	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	**15.00**	**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	3.47	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.59
Urgency of medical decision making	2.66	2.72

Technical Skill/Physical Effort (Mean)

Technical skill required	3.98	4.08
Physical effort required	3.19	3.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	4.05
Outcome depends on the skill and judgment of physician	4.13	4.23
Estimated risk of malpractice suit with poor outcome	3.69	3.89

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.75	2.88
Intra-Service intensity/complexity	3.66	3.83
Post-Service intensity/complexity	2.66	2.80

Additional Rationale

escribe the process by which your specialty society reached your final recommendation. *If your society has used an NPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialties are recommending the survey median of 1.16 work RVUs – a value that will accurately maintain the relationship between the intra-service work of the primary procedure and the work associated with the add-on 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. This code would always be reported in conjunction with code 64XX0 (the primary procedure code). It may also be reported in conjunction with 64XX2 (a second add on to be used for the third and any additional level(s)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64472

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Pain Mgmt/Pain Mgmt	How often? Commonly
Specialty Anesthesiology	How often? Commonly
Specialty Physcial Medicine & Rehabilitation	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 239566
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 90% of the patients receiving a single level injection will also undergo injection of a second level. Our estimate for a single level injection was 266,184. (266,184 * .90=239,566). Percentages come from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 83728	Percentage 34.94 %
Specialty Anesthesiology	Frequency 73283	Percentage 30.58 %
Specialty Physical Medicine & Rehabilitation	Frequency 24532	Percentage 10.24 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 119,783 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 90% of the patients receiving a single level injection will also undergo injection of a second level. Our estimate for a single level injection was 133,092 (133,092 * .90=119,783). Percentages come from the RUC database

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 41864	Percentage 34.94 %
Specialty Anesthesiology	Frequency 36642	Percentage 30.59 %
Specialty Physical Medicine & Rehabilitation	Frequency 12266	Percentage 10.24 %

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:64492 Tracking Number EE3 Specialty Society Recommended RVU: **1.16**

Global Period: ZZZ RUC Recommended RVU: **1.16**

CPT Descriptor: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female has chronic neck pain radiating toward her right shoulder. Previously performed assessments, tests and therapeutic trials have demonstrated the following: She has no neurological symptoms or weakness in her arms. Physical examination revealed restricted range of motion of her cervical spine due to pain. She has pain with palpation of her cervical spine and extension of her neck. These findings are consistent with facet pain at the C4-C5, C5-6 and C6-C7 levels. X-rays demonstrated multilevel facet arthropathy and spondylosis. The patient failed conservative treatments including physical therapy, nonsteroidal anti-inflammatory medications, opiate therapy with persistent pain and limitations in function. An MRI demonstrated facet arthropathy atC4-C5, C5-6 and C6-C7 along with multilevel degenerative disc disease. An electromyogram was negative for radiculopathy. Due to her failure with conservative treatment and persistent pain, diagnostic testing with cervical facet blocks under fluoroscopic guidance on the right at the C4-C5, C5-C6 and C6-C7 levels is indicated. This will be performed by blocking the right C4, C5, C6 and C7 medial branch nerves that innervate the C4-C5, C5-C6 and C6-C7 facet joints. (Imaging guidance (fluoroscopy or CT) is included in this code.) (Code ~~64XX2~~ 64492 includes only the work associated with injection of the third and any additional levels.)

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 45%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 24%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: After injections are placed at the C4 and C5 joints' medial branch nerves, and with the patient still prepped and draped, the fluoroscopic machine was re-oriented inferiorly and the entire procedure was repeated to block the C6 -7 joint's medial branch nerves.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, William Sullivan, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, William Donovan, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AAPMR, AANS.CNS. ASA, ASNR, ISIS, NASS				
CPT Code:	64492				
Sample Size:	1847	**Resp N:**	75	**Response:** 4.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**30.00**	67.50	1000.00
Survey RVW:	0.45	0.99	**1.10**	1.45	5.16
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	8.50	**13.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64492	**Recommended Physician Work RVU: 1.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64627	ZZZ	1.16	**RUC Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	13,490

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

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
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 58 **% of respondents:** 77.3 %

TIME ESTIMATES (Median)	CPT Code: 64492	Key Reference CPT Code: 64627	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	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	**15.00**	**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	3.43	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.60
Urgency of medical decision making	2.66	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.90	4.14
Physical effort required	3.24	3.34

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.76	4.09
Outcome depends on the skill and judgment of physician	4.07	4.21
Estimated risk of malpractice suit with poor outcome	3.64	3.90

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.69	2.86
Intra-Service intensity/complexity	3.53	3.79
Post-Service intensity/complexity	2.55	2.62

Additional Rationale

escribe the process by which your specialty society reached your final recommendation. *If your society has used an /PUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialties are recommending 1.16 work RVUs – a value that will accurately maintain the relationship between the intra-service work of the primary procedure and the work associated with the add-on code. This is the same value recommended for code +64491 – used to report injection of a second level. The incremental work is the same for each

of the add-on codes in this family. In three out of the four add-on codes, the surveys' median intraservice time was 15 minutes. The median was 13 minutes for this specific code as one of the specialties median response was only 7 minutes. The median intraservice time from the other specialties ranged from 12.5 to 25 minutes.

CPT will include an instruction that code 64492 should only be reported once per day.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code would always be reported in conjunction with 64XX0 (the primary procedure code) and 64XX1 (the add on code to describe the second level injected.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64472

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Pain Mgmt/Pain Mgmt	How often? Commonly
Specialty Anesthesiology	How often? Commonly
Specialty Physical Medicine & Rehabilitation	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 71870
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 30% of the patients who receive injections at two levels will also undergo injection at three or more levels. We estimated that 239,566 patients would undergo injection at two levels (239,566 * .30 = 71,870). Percentages come from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 25118	Percentage 34.94 %
Specialty Anesthesiology	Frequency 21985	Percentage 30.58 %
Specialty Physical Medicine & Rehabilitation	Frequency 7359	Percentage 10.23 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35,935 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 30% of the patients who receive injections at .wo levels will also undergo injection at three or more levels. We estimated that 119,783 patients would under go injection at two levels (119,783 * .30 = 35,935). Percentages come from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 12559	Percentage 34.94 %
Specialty Anesthesiology	Frequency 10992	Percentage 30.58 %
Specialty Physical Medicine & Rehabilitation	Frequency 3680	Percentage 10.24 %

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:64493 Tracking Number EE4 Specialty Society Recommended RVU: **1.70**

Global Period: 000 RUC Recommended RVU: **1.52**

CPT Descriptor: Injection(s), diagnostic or therapeutic agent, paravertebrel facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male has chronic right low back pain with radiation toward his buttock, limiting his ability to stand and walk for more than ten minutes. Previously performed assessments, tests and therapeutic trials have demonstrated the following: He has no radicular pain or weakness in his legs. He denies any bowel or bladder symptoms. Examination revealed no neurologic deficits, but the patient's pain complaints are reproduced by extension and palpation of the lumbar spine. X-rays demonstrated lumbar spondylosis at L3-4. The patient has failed treatment with physical therapy, non-steroidal anti-inflammatory medications and opiate therapy. An MRI demonstrated facet arthropathy at the L3-4 level and some mild multilevel degenerative disc disease. An electromyogram was negative for radiculopathy. Due to his failure with conservative care, diagnostic testing with a lumbar facet block under fluoroscopic guidance on the right at the L3-4 level is indicated. (Imaging guidance (fluoroscopy or CT) is included in this code.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 36%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 18%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Medical records and relevant history were reviewed with the patient, informed consent was obtained, and documentation completed. The patient was taken to the fluoroscopy suite for a right L3-4 facet joint injection. The patient was placed on a radiolucent carbon-fiber table in the prone position and prepped and draped in the usual fashion

Description of Intra-Service Work: The patient was monitored with continuous pulse oximetry, blood pressure and ECG monitors. The C-arm fluoroscopy machine was rotated and adjusted until the targeted facet joint (L3-4) was optima viewed. The skin and sub-cutaneous tissues were anesthetized with 3cc of 1% lidocaine. Then a 25-gauge 3.5-inc spinal needle was directed towards the facet joint under intermittent fluoroscopic guidance. Care was taken not to inadvertently injure vital neural structures or blood vessels. Once the joint was cannulated, approximately 0.2 cc of non-ionic contrast was infiltrated to confirm intra-articular spread and exclude any intra-vascular spread. Then a mixture

containing 0.3 cc of betamethasone (6mg/cc) mixed with 0.3 cc of 0.5% bupivacaine was slowly infiltrated into the facet joint. The needle was removed, a bandage was applied and the patient taken to the recovery area.

Description of Post-Service Work: The patient was monitored for an appropriate amount of time prior to being discharged to home. Patient was examined and pain levels assessed prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, William Sullivan, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, William Donovan, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AAPMR, AANS/CNS, ASA, ASNR, ISIS, NASS				
CPT Code:	64493				
Sample Size:	1847	**Resp N:**	88	**Response:** 4.7 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**87.50**	200.00	1500.00
Survey RVW:	1.00	1.44	**1.70**	2.00	6.75
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	40.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64493	**Recommended Physician Work RVU: 1.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**0.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**0.00**	**5.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27096	000	1.40	**RUC Time**

CPT Descriptor Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52000	000	2.23	**RUC Time**	948,337

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	197,342

CPT Descriptor 2 Injection(s); single tendon origin/insertion

Other Reference CPT Code	Global	Work RVU	Time Source
52311	000	1.54	**RUC Time**

CPT Descriptor 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)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 34.0 %

TIME ESTIMATES (Median)	CPT Code: 64493	Key Reference CPT Code: 27096	Source of Time RUC Time
Median Pre-Service Time	17.00	10.00	
Median Intra-Service Time	15.00	25.00	
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	**42.00**	**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	3.37	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	3.17
Urgency of medical decision making	2.37	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.87
Physical effort required	2.87	2.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.93	2.73
Outcome depends on the skill and judgment of physician	3.73	3.57
Estimated risk of malpractice suit with poor outcome	2.93	2.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.83	2.70
Intra-Service intensity/complexity	3.30	3.17
Post-Service intensity/complexity	2.67	2.57

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 Va' Recommendations for the appropriate formula and format.*

The specialties determined that Pre-service package 5 with some modification was the best fit for this procedure. The evaluation time was increased by 8 minutes to account for the thoroughness of the exam, the large number of records and imaging studies that must be reviewed and the time it takes to explain the procedure to the patient. Lumbar facet

injections are performed with the patient in the prone position and that requires 5 minutes of positioning time. These procedures are performed under sterile conditions requiring 5 minutes of scrub/dress/wait time.

It appears that our survey participants may not have fully understood that they were to include the work associated with fluoroscopy (or CT) in their responses. There are no other zero day global codes that include imaging guidance so we were unable to provide an example in our Reference Service List. Fluoroscopic guidance (code 77003) has a work RVU of 0.60. If this were added to the value of the current code (64475 with 1.41 RVUw) the result with be 2.01 RVUw. We are recommending the survey median of 1.70 which we believe understates the work; subtracting fluoroscopy means that the work of the injection is captured by the remaining 1.10 RVUw, less than the 1.15 RVUw assigned to a percutaneous insertion of an arterial line (code 36620)

A work RVUw of 1.70 will somewhat align with the work differential between cervical/thoracic and lumbar/sacral injections which is typically 0.37 - 0.44 (example: the tranlaminar epidural codes 62310 and 62311 (1.91-1.54 = 0.37). Our recommendation for code 64493 is validated by the survey median of 2.00.for code 64491 (Injection(s) diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single 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. This code could be reported on its own or in conjunction with +644X4 - an add-on code to describe the second level and +64XX5 - an add on code to describe the third and any additional level(s).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64475

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 Anesthesiology — How often? Commonly

Specialty Interventional Pain Mgmt/Pain Mgmt — How often? Commonly

Specialty Physical Medicine & Rehabilitation — How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 970856
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the national figure would be twice the Medicare frequency. Per the RUC database, the 2007 frequency for code 64475 was 485,428. Percentages come from the RUC database.

Specialty Anesthesiology	Frequency 311936	Percentage 32.12 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 284946	Percentage 29.34 %
Specialty Physcial Medicine & Rehabilitation	Frequency 128541	Percentage 13.23 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 485,428 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2007 Frequency per the RUC database was 485,428. Percentages also from the RUC database.

Specialty Anesthesiology	Frequency 155968	Percentage 32.12 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 142473	Percentage 29.34 %
Specialty Physical Medicine & Rehabilitation	Frequency 64271	Percentage 13.24 %

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 RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64494 Tracking Number EE5 Specialty Society Recommended RVU: **1.00**

Global Period: ZZZ RUC Recommended RVU: **1.00**

CPT Descriptor: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male has chronic right low back pain with radiation toward his buttock, limiting his ability to stand and walk for more than ten minutes. Previously performed assessments, tests and therapeutic trials have demonstrated the following: He has no radicular pain or weakness in his legs. He denies any bowel or bladder symptoms. Examination revealed no neurologic deficits, but the patient complains of chronic right low back pain with radiation toward his buttock, which limits his ability to stand and walk for more than ten minutes. He has no radicular pain but the patient's complaints are reproduced by extension and palpation of the lumbar spine. X-rays demonstrated lumbar spondylosis at the L3-4 and L4-5 levels. The patient failed prior treatment with physical therapy, non-steroidal anti-inflammatory medications and opiate therapy. Despite these treatments, the patient has had no improvement in pain or function. An MRI demonstrated facet arthropathy at the L3-4 and L4-L5 levels and some mild multilevel degenerative disc disease. An electromyogram was negative for radiculopathy. Due to his failure with conservative care, diagnostic testing with a lumbar facet blocks under fluoroscopic guidance on the right at the L3-4 and L4-L5 and levels is indicated. (Imaging guidance (fluoroscopy or CT) is included in this code.) (Code 64XX4 includes only the work associated with injection of the second level.)

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 37%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 20%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

escription of Intra-Service Work: After an injection of the L3-4 facet joint and with the patient still prepped and draped, the C-arm fluoroscopy machine was re-oriented and the entire procedure was repeated at the L4-L5 facet joint.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, William Sullivan, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, William Donovan, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AAPMR, AANS/CNS, ASA, ASNR, ISIS, NASS				
CPT Code:	64494				
Sample Size:	1847	**Resp N:**	70	**Response:** 3.7 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**62.50**	200.00	1500.00
Survey RVW:	0.50	0.98	**1.10**	1.32	5.75
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64494	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64626	ZZZ	3.82	**Harvard Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	13,490

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

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
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 55 **% of respondents:** 78.5 %

TIME ESTIMATES (Median)	CPT Code: 64494	Key Reference CPT Code: 64626	Source of Time Harvard Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	16.00	
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**	**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	3.31	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.49
Urgency of medical decision making	2.56	2.69

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.76
Physical effort required	2.91	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.31	3.67
Outcome depends on the skill and judgment of physician	3.78	3.91
Estimated risk of malpractice suit with poor outcome	3.33	3.65

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.67	2.84
Intra-Service intensity/complexity	3.27	3.53
Post-Service intensity/complexity	2.53	2.64

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Valu Recommendations for the appropriate formula and format.*

The specialties are recommending a work RVU of 1.00 - slightly less than the survey median to maintain the relationship between the intra-service work of the primary procedure and the work associated with the add-on 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. This code would always be reported in conjunction with code 64XX3 (the primary procedure code). It may also be reported in conjunction with 64XX5 (a second add on to be used for the third and any additional level(s)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64476

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Commonly
Specialty Interventional Pain Mgmt/Pain Mgmt	How often? Commonly
Specialty Physical Medicine & Rehabilitation	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 873770
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.. We estimate that 90% of the patients receiving a single level injection will also undergo injection of a second level. Our estimate for a single level injection was 970,856 (970,856 * .90 = 873,770). Percentages come from the RUC database.

Specialty Anesthesiology	Frequency 310101	Percentage 35.49 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 288781	Percentage 33.05 %
Specialty Physcial Medicine and Rehabilitation	Frequency 99785	Percentage 11.42 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 436,885 If this is a recommendation from multiple specialties please estimate frequency and percentage for each

specialty. Please explain the rationale for this estimate. We estimate that 90% of the patients receiving a single level injection will also undergo injection of a second level. Our estimate for a single level injection was 485,428 (485,428 * .90 = 436,885). Percentages come from the RUC database.

Specialty Anesthesiology	Frequency 155051	Percentage 35.49 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 144473	Percentage 33.06 %
Specialty Physical Medicine & Rehabilitation	Frequency 49892	Percentage 11.41 %

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. 20526

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:64495 Tracking Number EE6 Specialty Society Recommended RVU: **1.00**

Global Period: ZZZ RUC Recommended RVU: **1.00**

CPT Descriptor: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male has chronic right low back pain with radiation toward his buttock, limiting his ability to stand and walk for more than ten minutes. Previously performed assessments, tests and therapeutic trials have demonstrated the following: He has no radicular pain or weakness in his legs. He denies any bowel or bladder symptoms. Examination revealed no neurologic deficits, but the patient's pain complaints are reproduced by extension and palpation of the lumbar spine. X-rays demonstrated lumbar spondylosis at the L3-L4, L4-L5 and L5-S1 levels. The patient failed prior treatment with physical therapy, non-steroidal anti-inflammatory medications and opiate therapy. Despite these treatments, the patient has had no improvement in pain or function. An MRI demonstrated facet arthropathy at the L3-L4, L4-L5 and L5-S1 levels and some mild multilevel degenerative disc disease. An electromyogram was negative for radiculopathy. Due to his failure with conservative care, diagnostic testing with a lumbar facet blocks under fluoroscopic guidance on the right at the L3-L4, L4-L5 and L5-S1 levels is indicated. (Imaging guidance (fluoroscopy or CT) is included in this code.) (Code 64XX5 includes only the work associated with injection of the third and any additional levels.)

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 39%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 19%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: After injections at the L3-4 and L4-5 joints, and with the patient still prepped and draped in the prone position, the C-arm fluoroscopy machine was re-oriented and the entire procedure was repeated the L5-S1 facet joint.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Fred Davis, MD, William Sullivan, MD, Frederick Boop, MD, Alexander Mason, MD, Marc Leib, MD, William Donovan, MD, Rodney Lee Jones, MD, Charles Mick, MD				
Specialty(s):	AAPM, AAPMR, AANS/CNS, ASA, ASNR, ISIS, NASS				
CPT Code:	64495				
Sample Size:	1847	**Resp N:**	64	**Response:** 3.4 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.75	**46.50**	150.00	1500.00
Survey RVW:	0.49	0.90	**1.00**	1.17	5.25
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	8.75	**15.00**	20.00	40.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	64495	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64623	ZZZ	0.99	**Harvard Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	13,490

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

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
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 52 **% of respondents:** 81.2 %

TIME ESTIMATES (Median)	CPT Code: 64495	Key Reference CPT Code: 64623	Source of Time Harvard Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	16.00	
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**	**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	3.21	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.25
Urgency of medical decision making	2.56	2.69

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.83
Physical effort required	2.92	3.04

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.23	3.62
Outcome depends on the skill and judgment of physician	3.69	3.92
Estimated risk of malpractice suit with poor outcome	3.10	3.52

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.63	2.83
Intra-Service intensity/complexity	3.23	3.52
Post-Service intensity/complexity	2.44	2.62

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Valu... Recommendations for the appropriate formula and format.*
The specialties are recommending the survey median work RVU of 1.00 to maintain the relationship between the intra-service work of the primary procedure and the work associated with the add-on code.

CPT will include an instruction that code 64495 should only be reported once per day.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code would always be reported in conjunction with code 64493 (the primary procedure code). It may also be reported in conjunction with 64494 (an add on to be used for the second level

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64476

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Commonly
Specialty Interventional Pain Mgmt/Pain Mgmt	How often? Commonly
Specialty Physcial Medicine & Rehabilitation	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 262131
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We estimate that 30% of the patients who receive injections at two levels will also undergo injection at three or more levels. We estimated that 873,770 patients would undergo injection at two levels (873,770 * .30 = 262,131). Percentages comes from the RUC database

Specialty Anesthesiology	Frequency 93030	Percentage 35.48 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 86634	Percentage 33.04 %
Specialty Physicial Medicine & Rehabilitation	Frequency 29935	Percentage 11.41 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 131,066 If this is a recommendation from multiple specialties please estimate frequency and percentage for each

specialty. Please explain the rationale for this estimate. We estimate that 30% of the patients who receive injections at two levels will also undergo injection at three or more levels. We estimated that 436,885 patients would undergo injection at two levels (436,885 * .30 = 131,066). Percentages come from the RUC database

Specialty Anesthesiology	Frequency 46515	Percentage 35.48 %
Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 43317	Percentage 33.04 %
Specialty Physical Medicine & Rehabilitation	Frequency 14968	Percentage 11.42 %

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
Practice Expense Summary of Recommendation
000 Day Global Period
Facility Direct Inputs

CPT Long Descriptor:

64490: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

64493: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

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 consisting of RUC and CPT and health policy representatives of the North American Spine Society (NASS), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the International Spine Intervention Society (ISIS), the American Society of Anesthesiologists (ASA), the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS) was convened to review the practice expense inputs for the newly revised facet injection codes. The panel included physicians in solo practice, academic settings, and large group practices and represented a multitude of geographic locations.

History

The practice expense inputs for 52 for the spinal injection codes were presented to the practice expense review committee in August of 2001. Many of these codes require imaging for performance. The imaging code 76005 was presented to the practice expense review committee in 2003. In order to assure the absence of duplication of inputs when these codes were billed together, in January 2004 the injection codes were reexamined in conjunction with the separate imaging code and further refined.

During the 2001 and 2003 presentations, it was concluded that one clinical staff person, a mixed staff blend RN/LPN/MA assisted during the procedure. The consensus panel convened to review the newly created facet codes has identified a change in the standard of practice during the past 6-8 years. Currently a licensed radiation therapist is typically required by law in many states to operate the fluoroscopy machine. A second clinical assistant is required to assist the physician performing the procedure.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carried out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure. The staff blend times which are recommended are unchanged from the values approved by the PEAC and RUC in January 2004.

tra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Phone calls and call in prescriptions are completed.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

64490: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

64493: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

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History

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During the 2001 and 2003 presentations, it was concluded that one clinical staff person, a mixed staff blend RN/LPN/MA assisted during the procedure. The consensus panel convened to review the newly created facet codes has identified a change in the standard of practice during the past 6-8 years. Currently a licensed radiation therapist is typically required by law in many states to operate the fluoroscopy machine. A second clinical assistant is required to assist the physician performing the procedure.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff completes pre-service diagnostic and referral forms. They schedule space and equipment needed. Clinical staff will provide and review educational materials and information prior to the procedure. Clinical staff will also call in any prescriptions necessary for the patient prior to the procedure and contact the patient prior to the procedure to confirm pre-procedure instructions are being carried out. Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

The staff blend times which are recommended are unchanged from the values approved by the PEAC and RUC in January 2004.

The RT obtains and displays the previous images.

Intra-Service Clinical Labor Activities:

Clinical staff reviews the chart to be certain all pre-procedure testing is available and the medical history is current. The patient will be greeted and gowned and four vital signs obtained. The procedure is reviewed. The procedure room is prepared, making certain supplies and equipment necessary are available. Clinical staff assists the physician with prepping, positioning, and providing anesthesia. The clinical staff remain in the room and assist the physician with the entire procedure. After completion of the procedure, clinical staff will monitor the patient. The panel estimates the patient is monitored for 40 minutes. We allocated ¼ of this time (10 minutes) to staff to allow for multi-tasking. Staff will clean the room; check dressings; and provide instructions on pain control and follow-up visits.

RT prepares the imaging equipment and inputs patient and procedure information. They position the C-arm and assist in final positioning of the patient and obtain scout films. They perform imaging as required during the procedure. At the end of the procedure, they clean the equipment and process and store hard copies of films.

Post-Service Clinical Labor Activities:

Phone calls and call in prescriptions are completed.

CPT Code: 64491 64492 64494-5

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Period
Facility Direct Inputs

CPT Long Descriptor:

64491: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level

64492: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)

64494: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level

64495: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

We added an additional 2 minutes for a longer phone call for X2 and X5. When multiple levels (three or more) are injected, patients typically require longer times coordinating pain and prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

64491: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level

64492: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)

64494: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level

64495: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:
The clinical staff remains in the room and assists the physician while the additional levels are injected.

The RT remains in the room and performs imaging as required while the additional levels are injected.

Post-Service Clinical Labor Activities:

We added an additional 2 minutes for a longer phone call for 64492 and 64495. When multiple levels (three or more) are injected, patients typically require longer times coordinating pain and prescriptions

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				64490			64491			64492			64493			64494			64495		
	Meeting Date: April 2009			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)		
2		CMS																			
3	LOCATION	Code		Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility
4	GLOBAL PERIOD			0	0	0	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	0	0	0	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
5	STAFF Type			RT LO41B	RN/LPN/MTA L037D	RN/LPN/MTA L037D	RT LO41B	RN/LPN/MTA L037D	RN/LPN/MTA L037D	RT LO41B	RN/LPN/MTA L037D	RN/LPN/MTA L037D	RT LO41B	RN/LPN/MTA L037D	RN/LPN/MTA L037D	RT LO41B	RN/LPN/MTA L037D	RN/LPN/MTA L037D	RT LO41B	RN/LPN/MTA L037D	RN/LPN/MTA L037D
6	TOTAL CLINICAL LABOR TIME			32.0	61.0	24.0	15.0	15.0	0.0	15.0	17.0	2.0	32.0	61.0	24.0	15.0	15.0	0.0	15.0	17.0	2.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0	11.0	21.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	11.0	21.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			29.0	47.0	0.0	15.0	15.0	0.0	15.0	15.0	0.0	29.0	47.0	0.0	15.0	15.0	0.0	15.0	15.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	3.0	3.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0	3.0	3.0	0.0	0.0	0.0	0.0	2.0	2.0
10	PRE-SERVICE																				
11	Start: Following visit when decision for surgery or procedure made																				
12	Complete pre-service diagnostic & referral forms				3	3								3	3						
13	Coordinate pre-surgery services				0	5								0	5						
14	Schedule space and equipment in facility				0	5								0	5						
15	Provide pre-service education/obtain consent				5	5								5	5						
16	Follow-up phone calls & prescriptions				3	3								3	3						
17	Other Clinical Activity (please specify)- Pull & hang prior imaging studies for MD to review			3	0	0							3	0	0						
18	End: When patient enters office/facility for surgery/procedure																				
19	SERVICE PERIOD																				
20	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure																				
21	Review charts				2									2							
22	Greet patient and provide gowning				3									3							
23	Obtain vital signs				5									5							
24	Provide pre-service education/obtain consent																				
25	Prepare room, equipment, supplies			3	3								3	3							
26	Setup scope (non facility setting only)																				
27	Prepare and position patient/ monitor patient/ set up IV			3	3								3	3							
28	Sedate/apply anesthesia																				
29	Intra-service																				
30	Assist physician in performing procedure			15	15		15	15		15	15		15	15		15	15		15	15	
31	Post-Service																				
32	Monitor pt. following service/check tubes, monitors, drains				10									10							
33	Clean room/equipment by physician staff			3	3								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				3									3							
39	Discharge day management																				
40	Other Clinical Activity (please specify) Process, hang, file films and review study with interpreting MD			5									5								
41	End: Patient leaves office/facility																				

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				64490			64491			64492			64493			64494			64495		
2	Meeting Date: April 2009	CMS		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level			Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)		
3	LOCATION	Code		Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility
42	POST-SERVICE Period																				
43	Start: Patient leaves office/facility																				
44	Conduct phone calls/call in prescriptions				3	3					2	2		3	3					2	2
45	End: with last office visit before end of global period																				
46	MEDICAL SUPPLIES	CMS Code	Unit																		
47	pack, basic injection	SA041	item		1									1							
48	pack, minimum multi specialty visit	SA048	item		1									1							
49	drape, sterile, c-arm, fluoro	SB008	item		1									1							
50	Spinal Needle	SC028	item		1			1			1			1			1			1	
51	Syringe 10cc	SC051	item		1						1			1						1	
52	Bupivicaine 0.25%	SH021	item		3cc			3cc			3cc			5cc			5cc			5cc	
53	film, dry, radiographic, 8in x 10in	SK025	item		2									2							
54	Equipment	CMS Code																			
55	stretcher	EF018			53	min								53	min						
56	room, radiographic-fluoroscopic	EL014			24			15min			15 min			24			15 min			15 min	
57	x-ray view box, 4 panel	ER067			24									24							
58	printer, dye sublimation (photo, color)	ED031			24									24							
59																					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Myocardial Perfusion Imaging

The RUC identified 78465, 78478, and 78480 as potentially misvalued through its Codes Frequently Reported Together screening mechanism, as combinations of these codes are reported together more than 95% of the time. To address its concerns, the RUC recommended that the services be referred to CPT to create bundled services that accurately describe the work that is typically performed. The CPT Editorial Panel, at its October 2008 meeting, deleted the existing family of myocardial perfusion imaging services (which included 78460, 78461, 78464, 78465, 78478, and 78480) and created four new Category I CPT codes to describe the work. These new codes are 78451, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic),* 78452, *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*, 78453, *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic),* and 78454, *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*

1570

78452

The RUC discussed CPT code 78452, which is the most complex code within this family and accounts for the greatest utilization. The specialty society provided a detailed description of the work included within the service. The RUC discussed the survey results and noted that there was an exceptionally high median survey performance rate among the 83 respondents, which adds significant support to the survey data. As such, the RUC agreed that the median survey physician times of 10 minutes pre-service, 20 minutes intra-service, and 10 minutes immediate post-service time accurately reflect the time required to perform this service. However, the RUC agreed that the median survey work RVU of 1.87 was too high and did not accurately reflect the work being performed in the surveyed code. The RUC agreed that the key reference service, 78492, *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress*, was inappropriate because of the wide difference in intra-service time between the

survey code and reference code (20 minutes and 55 minutes, respectively). The RUC agreed a better reference code for 78452 is MPC code 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 8, intra-service = 20, post-service = 10). The RUC and the specialty society presenters agreed that the two services are comparable in intensity and work. However, the RUC did note that the surveyed code contains two additional minutes of pre-service time, which is related to the physician management of the injection. **With a direct crosswalk from reference code 70496, the RUC recommends a work RVU of 1.75 for CPT code 78452.**

78451

The RUC reviewed the specialty society's survey results and work RVUs recommended by the specialty society for 78451. The RUC discussed the survey results and noted that there was an exceptionally high median survey performance rate among the 83 respondents, which adds significant support to the survey responses. The RUC agreed that that survey physician times of 10 minutes pre-service, 15 minutes intra-service, and 10 minutes immediate post-service time accurately reflect the time required to perform this service. However, the RUC agreed that the median work RVU of 1.50 was too high and did not accurately reflect the work being performed in the surveyed code. In order to maintain relativity with 78452, the RUC derived the recommended RVU for 78451 by calculating the relationship between the median survey RVUs of X1 and X2 and maintaining this relationship between the recommended RVU for 78451 and 78452. The survey work RVU relationship between 78451 : 78452 is (1.50 : 1.87) resulting in a relationship between the recommended RVU for 78451 : 78452 (1.40 : 1.75).

1571

78451 =	1.50	*1.40*
78452 =	1.87	1.75

The RUC agreed that this computed work RVU, 1.40 RVUs, maintains the relativity of the original survey data and is an appropriate measure of the work for 78451. The RUC also compared 78451 to 45308, *Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery* (work RVU = 1.40, intra-service time = 15 minutes) and agreed that it supports the RUC's recommendation of 1.40 work RVUs for 78451. **The RUC recommends a work RVU of 1.40 for CPT code 78451, which maintains the relativity between the 78451 and 78452 and is the appropriate value for the service.**

78453

The RUC reviewed the survey results for 78453 agreed with the specialty society that the survey median physician times were too high, and did not reflect the time required to perform this service. The RUC agreed that the surveyed 25th percentile physician time (pre-service = 5, intra-service = 10, post-service = 5) and 25th percentile work RVU of 1.00 accurately reflects the work and time

required to perform this service. In addition, the RUC compared 78453 to 78315, *Bone and/or joint imaging; 3 phase study* (work RVU = 1.02, pre-service = 5, intra-service = 8, post-service = 5) and noted the similarity in the physician time and work. **Therefore, the RUC recommends the 25th percentile time and work RVU of 1.00 for CPT code 78453.**

78454

The RUC reviewed the survey results for 78454 and agreed with the specialty society that the survey median physician times were too high, and did not accurately reflect the time required to perform this service. The RUC agreed that the surveyed 25th percentile times (pre-service = 5, intra-service = 15, post-service = 5) and that the 25th percentile work RVU of 1.34 accurately reflect the work and time required to perform this service. In addition, the RUC compared 78453 to 73721, *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.35, pre-service = 0, intra-service = 20, post-service = 0). The RUC agreed that 73721 was a good alternative reference code because the physician work for both codes is similar and the total physician times are the same, though the intra-service work of 73721 is slightly more intense. Based on the survey results and similarity to the reference code, the RUC agrees that the 25th percentile work RVU is appropriate. **Therefore, the RUC recommends the 25th percentile time and work RVU of 1.34 for CPT code 78454.**

1572

PLI

The RUC recommends that the PLI RVUS be cross-walked from the original base-codes: 78451 = 78464, 78452 = 78465, 78453 = 78460, and 78453 = 78461. The RUC also recommends that the PLI RVU for the technical component of each service be 0.00, and the PLI RVU be applied only to the physician component.

Practice Expense

The RUC reviewed the practice expense inputs approved by the PE Subcommittee and accepted them.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Myocardial perfusion and cardiac blood pool imaging studies may be performed at rest and/or during stress. When performed during exercise and/or pharmacologic stress, the appropriate stress testing code from the 93015-93018 series should be reported in addition to code(s) 78451- 78454 ~~78460-78465~~, 78472-78492.				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●78451	L1	Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	XXX	1.40
●78452	L2	multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	XXX	1.75
●78453	L3	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	XXX	1.00
●78454	L4	multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	XXX	1.34
D 78460		~~Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification~~	XXX	N/A
D 78461		~~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~~	XXX	N/A
D 78464		~~Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification~~	XXX	N/A
D 78465		~~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~~ (78460–78465 have been deleted. To report, see 78451–78454)	XXX	N/A
D 78478		~~Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)~~ ~~(Use 78478 in conjunction with codes 78460, 78461, 78464, 78465)~~	XXX	N/A

1573

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 78480		~~Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)~~ ~~(Use 78480 in conjunction with codes 78460, 78461, 78464, 78465)~~ (78478 and 78480 have been deleted. To report, see 78451–78454)	XXX	N/A
78481		Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	XXX	0.98 (No Change)
78483		multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification (Do not report 78481–78483 in conjunction with 78451–78454)	XXX	1.47 (No Change)
78580		Pulmonary perfusion imaging, particulate (Do not report 78580 in conjunction with 78451-78454)	XXX	0.74 (No Change)

1574

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78451 Tracking Number Specialty Society Recommended RVU: **1.50**

Global Period: XXX RUC Recommended RVU: **1.40**

CPT Descriptor: Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male with prior MI x2 and CHF has three-vessel disease by cath. A resting myocardial perfusion scan is ordered to assess viable tissue for possible CABG.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician determines the appropriateness of the requested study; prescribes, oversees and directs the intravenously administered dose. The physician directs the technologist to adjust the acquisition protocol as necessary for the individual patient. If wall motion and/or ejection fraction are performed, the physician assesses the patient's cardiac rhythm, directs the technologist in lead placement for optimal gating signal and any necessary adjustments in gating acquisition parameters based on individual rhythm assessment. The physician is available to answer questions for the technologist and to review components of the study throughout the study.

Description of Intra-Service Work: The study consists of an acquisition of either a stress or a rest tomographic (SPECT) data set, synchronized (gated) to the patient's electrocardiogram when performed. The physician verifies the completeness and adequacy of the data before completion of the study and may order additional imaging if necessary.

The images are reviewed for artifacts and abnormal extracardiac distribution. Three different tomographic data sets are reviewed and re-reconstructed, if necessary. The physician compares the three tomographic views for differences similarities that would suggest ischemia or scar. Qualitative assessment of ventricular wall function and perfusion are made in a standardized manner, with each segment scored on a semi-quantitative scale when performed. Wall motion is qualitatively scored for motion and thickening. This occurs in a standardized segment model for the dataset with each segment scored as normal, mildly hypokinetic, moderately hypokinetic, severely hypokinetic, akinetic, or dyskinetic. Attention is paid to the assessment of regional myocardial function and to the percent of myocardium that is regionally

dysfunctional in order to judge the amount of underlying myocardial scar (or stress induced ischemia). The extent and severity of perfusion defects and their relationship to vascular geographic territories are noted.

When performed, wall motion and thickening quantitative data are generated and reviewed for the image set. The segmental wall motion data are compared to the perfusion images to generate a clinically relevant wall motion analysis for the individual patient. When performed, left ventricular ejection fraction is reported after confirming the correctness of the regions of interest that were selected for the calculation. Digital data of perfusion and ventricular function are reviewed after the qualitative assessment, in part to refine the qualitative impression. Comparison to relevant prior studies is done. A report is dictated for the medical record.

Description of Post-Service Work:
The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician throughout the procedure provides regulatory review and oversight.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	Drs. Van Decker, McKusick, McGinty, Dillehay				
Specialty(s):	ACC, ACNP, ACR, ASNC, SMN				
CPT Code:	78451				
Sample Size: 741	**Resp N:** 78	**Response:** 10.5 %			
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	21.00	**73.00**	400.00	6800.00
Survey RVW:	0.49	1.38	**1.50**	1.84	3.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	78451	**Recommended Physician Work RVU: 1.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**7.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
78494	XXX	1.19	**RUC Time**	6,026

CPT Descriptor 1 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	83,290

CPT Descriptor 2 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
78812	XXX	1.93	**RUC Time**

CPT Descriptor Positron emission tomography (PET) imaging; skull base to mid-thigh

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 42.3 %

TIME ESTIMATES (Median)	CPT Code: 78451	Key Reference CPT Code: 78459	Source of Time RUC Time
Median Pre-Service Time	10.00	0.00	
Median Intra-Service Time	15.00	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	**35.00**	**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	3.61	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.70
Urgency of medical decision making	3.91	3.78

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.15
Physical effort required	2.00	2.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.61	3.67
Outcome depends on the skill and judgment of physician	4.52	4.45
Estimated risk of malpractice suit with poor outcome	3.45	3.39

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.24	3.45
Intra-Service intensity/complexity	3.88	4.00
Post-Service intensity/complexity	3.15	3.18

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 of Nuclear Medicine, American College of Nuclear Physicians, American College of Cardiology, American College of Radiology and the American Society of Nuclear Cardiology convened a consensus expert panel to review the random sample data from the professional societies. The panel notes that this new code represents a combination of prior codes.

Survey Results

The panel noted that the survey median RVU was 1.50 with a 25th percentile of 1.36 and a 75th percentile of 1.84. The median value of 1.50 RVUs represents a significant decrease from the existing values (1.89 for the combined RVU of the three codes).

n developing a recommendation for 78451, our expert panel was concerned that the reference service list (RSL) could ıave been misleading to surveyees since the most frequently chosen reference code of 78459 is a tomographic metabolic-only PET code which does not include a further "half-study" evaluation of wall motion/ ejection fraction in its description or valuation. Recognizing the work intensity involved in the new code and the limitations and potential ambiguity of the current survey, the panel felt a recommendation of at least the 50 percentile value of 1.50 RVU was appropriate. The panel also noted that the approximate total time of the study by survey was not unreasonable. The differences from the RUC times in the database may reflect the respondents incorrectly allocating time into pre, intra and post service buckets, and the panel made adjustments to this allocation by time shifting pre and post into intra service time in its recommendation for consistency purposes.

Comparison to the Most Frequently Chosen Reference Code

The panel compared 78451 to the most frequently chosen reference code 78459 (RVU 1.50). Once again, it was noted 78459 describes a single session acquisition tomographic study in the PET family but without the added work of wall motion/ EF analysis and reporting. Respondents judged the intensity/complexity measures of the new code as the same or higher in 8/11 categories.

Comparison to "Similar Codes"

The panel notes that 78451 involves a tomographic imaging dataset with quantitative data with additional datasets of motion and functionality. This involves the gathering and interpretation of more clinical data than the single tomographic PET dataset acquisitions of 78459 and 78491 (both 1.50 RVU), albeit overseeing a SPECT radiopharmaceutical rather than a PET radiopharmaceutical. The panel believes this supports a recommendation of at least a value of 1.50 RVU.

Building Block Approach (within the perfusion family)

Single acquisition session SPECT with wall motion and EF (new CPT code 78451) is more complex than single and ıultiple planar imaging with WM/EF (new CPT code 78453 for single planar; new CPT code 78454 for multiple planar) ɔut less complex than multiple acquisition session SPECT with WM/EF (new CPT code 78452).

SERVICES REPORTED WITH MULTIPLE 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. Single studies may be at rest or with stress. If performed with stress the appropriate stress code is billed separately in addition to the appropriate procedure code. It is common for multiple physicians to be involved in this procedure, cardiologists, radiologists and nuclear medicine physicians are the most common.
3.
4. Table 1
5. Source: 2006 SAF 5% Carrier File
6. National Estimate - 20 times the numbers generated above from the 5% file

7. For low volume procedures or combinations. These National Estimates may be particularly unreliable.
8.

9.	Combination of more than codes	93015	93016	93017	93018	Performed Alone
10.						
11.	78460	40	60	20	60	6,160
12.	78461	1,020	120	-	120	25,080
13.	78464	18,500	260	380	1,760	60,680
14.	78465	1,432,240	14,080	41,780	91,580	1,441,860
15.	78481	18,140	140	580	1,000	16,840
16.	78483	14,520	80	40	740	8,780
	560 Performed Alone	899,920	1,000,220	113,640	1,125,940	

17.

18.		Global	RVU	Pre	Intra	Post
19.	93015	XXX	0.75	2	15	4
20.	93016	XXX	0.45	10	38	10
21.	93017	XXX	0.00	0	0	0
22.	93018	XXX	0.30	2	5	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT 78464 sometimes billed with 78478 and/or 78480
In 2006 utilization for 78464 was 79,754 Global and 45,973 Professional.

Physician Breakdown For Professional Billings

46.94 %	DIAGNOSTIC RADIOLOGY
35.18 %	CARDIOLOGY
10.91 %	NUCLEAR MEDICINE
3.18 %	INTERNAL MEDICINE
2.28 %	INTERVENTIONAL RADIOLOGY
0.47 %	VASCULAR SURGERY

Physician Breakdown For Global Billings

89.17 %	CARDIOLOGY
3.37 %	INTERNAL MEDICINE
3.16 %	DIAGNOSTIC RADIOLOGY
2.66 %	NUCLEAR MEDICINE
0.55 %	VASCULAR SURGERY
0.40 %	INDEPENDENT DIAGNOSTIC TESTING FACILITY

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 Nuclear Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 160000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. See 2006 breakdown noted above.

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? 80,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 CMS data base. See breakdown noted above.

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? No

If no, please select another crosswalk and provide a brief rationale. Recommend CPT 78464; this code represents the current PLI for MPI inherent in 78451. The PLI RVU for the TC component should be 0.00.

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:78452 Tracking Number Specialty Society Recommended RVU: **1.87**

Global Period: XXX RUC Recommended RVU: **1.75**

CPT Descriptor: Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male has hypertension, hyperlipidemia, and a family history of coronary artery disease. He has been experiencing atypical chest pain and advancing shortness of breath while walking. His resting electrocardiogram is abnormal, showing sinus rhythm, possible inferior wall MI and non-specific ST-T wave abnormalities. He is referred for a stress and rest myocardial perfusion study with wall motion and ejection fraction evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician determines the appropriateness of the requested study; prescribes, oversees and directs the intravenously administered dose. The physician directs the technologist to adjust the acquisition protocol as necessary for the individual patient. If wall motion and/or ejection fraction are performed, the physician assesses the patient's cardiac rhythm, directs the technologist in lead placement for optimal gating signal and any necessary adjustments in gating acquisition parameters based on individual rhythm assessment. The physician is available to answer questions for the technologist and to review components of the study throughout the study.

Description of Intra-Service Work: The study consists of acquisition of a stress and a rest (and/or redistribution) tomographic (SPECT) data sets, synchronized (gated) to the patient's electrocardiogram when performed. The physician verifies the completeness and adequacy of the data sets before completion of the study and may ord additional imaging if necessary.

The images are reviewed for artifacts and abnormal extracardiac distribution. Three different tomographic datasets are reviewed for each acquisition, and re-reconstructed, if necessary. The physician compares the tomographic datasets for differences or similarities that would suggest ischemia or scar. Qualitative assessment of ventricular wall function and

perfusion are made in a standardized manner, with each segment scored on a semi-quantitative scale when performed. Wall motion is qualitatively scored for motion and thickening. This occurs in a standardized segment model for the dataset with each segment scored as normal, mildly hypokinetic, moderately hypokinetic, severely hypokinetic, akinetic, or dyskinetic. Attention is paid to the assessment of regional myocardial function and to the percent of myocardium that is regionally dysfunctional in order to judge the amount of underlying myocardial scar (or stress induced ischemia). The extent and severity of perfusion defects and their relationship to vascular geographic territories are noted.

When performed, wall motion and thickening quantitative data are generated and reviewed. The segmental wall motion data are compared to the perfusion images to generate a clinically relevant wall motion analysis for the individual patient. When performed, left ventricular ejection fraction is noted after confirming the correctness of the regions of interest that were selected for the calculation. Digital data of perfusion and ventricular function are reviewed after the qualitative assessment, in part to refine the qualitative impression. Comparison to relevant prior studies is done. A report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician throughout the procedure provides regulatory review and oversight.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2009				
Presenter(s):	Drs. Van Decker, McKusick, McGinty, Dillehay				
Specialty(s):	ACC, ACNP, ACR, ASNC, SNM				
CPT Code:	78452				
Sample Size:	741	**Resp N:**	83	**Response:** 11.2 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	425.00	**900.00**	2000.00	8000.00
Survey RVW:	0.95	1.58	**1.87**	2.00	3.75
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	15.00	**20.00**	25.00	70.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	78452	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**7.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		
Immediate Post Service-Time:	**10.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**		
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78492	XXX	1.87	**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	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	83,290

CPT Descriptor 1 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71275	XXX	1.92	**RUC Time**	502,043

CPT Descriptor 2 Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
78812	XXX	1.93	**RUC Time**

CPT Descriptor Positron emission tomography (PET) imaging; skull base to mid-thigh

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 51 **% of respondents:** 61.4 %

TIME ESTIMATES (Median)	CPT Code: 78452	Key Reference CPT Code: 78492	Source of Time RUC Time
Median Pre-Service Time	10.00	0.00	
Median Intra-Service Time	20.00	55.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
edian 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**	**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	3.88	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.86
Urgency of medical decision making	3.98	3.88

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	4.25
Physical effort required	2.71	2.69

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.82	3.76
Outcome depends on the skill and judgment of physician	4.41	4.43
Estimated risk of malpractice suit with poor outcome	3.90	3.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.29	3.29
Intra-Service intensity/complexity	4.24	4.14
Post-Service intensity/complexity	3.22	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 Valu Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine, American College of Nuclear Physicians, American College of Cardiology, American College of Radiology and the American Society of Nuclear Cardiology convened a consensus expert panel to review the random sample AMA RUC survey summary data from the professional societies. The panel notes that this new code represents a combination of three previous codes just recently surveyed for the 2005 Five Year Review (a 2005 survey more robust in 125 respondents).

Survey Results

The panel noted that the survey median RVU was 1.87 with a 75th percentile of 2.00 and a 25th percentile of 1.58. This median value of 1.87 RVUs represents a significant decrease from the existing values (2.26 for the combined RVU of the three codes). The existing values reflect the RUC recommendations from the most recent Five Year Review, which involved data from 125 surveys and extensive analysis by the RUC, which specifically took into account that the services were almost always performed in combination.

In developing a recommendation for 78452, our expert panel was concerned that the RSL could have been misleading to surveyees since the most frequently chosen reference code of 78492 is a multiple imaging session tomographic PET "perfusion-only" code which does not include a further "half study" evaluation of wall motion or ejection fraction in its description or valuation. Recognizing the work intensity involved in the new code and the limitations and potential ambiguity of the current survey, the panel felt a recommendation of at least the 50th percentile value of 1.87 RVU was appropriate. The panel also noted that the approximate total time by survey of the new code was overall consistent with the combination of the 2005 consensus results. The differences from the RUC times in the database may reflect the respondents incorrectly allocating time into pre, intra and post service buckets, and the panel made adjustments to this allocation by time shifting pre and post into intra service time in its recommendation for consistency purposes.

Comparison to Most Frequently Chosen Code

The panel compared 78452 to the most frequently chosen reference code 78492. Once again, it was noted that this is a code of multiple imaging session tomographic PET "perfusion only" but without the added work of wall motion/ejection fraction analysis and reporting. Respondents judged the intensity/complexity measures of the new code as significantly higher (6) or about the same (3) in 9/11 categories.

Comparison to "Similar Codes"

The panel notes that 78452 involves the comparison of multiple session tomographic imaging datasets with multiple quantification data in addition to datasets of motion, functionality and attenuation correction. It also involves the mandated NRC radiation safety compliance oversight associated with multiple imaging sessions. It should entail more work on an estimation of magnitude than the interpretation of single session tomographic imaging datasets (especially without further motion datasets), such as 78491 (single session PET perfusion only – 1.50 RVU). The panel believes that 784X2 is at least similar in physicians work to 78812 (PET skull to thigh – 1.93 RVU) and 71275 (CT Angiogiography Chest – 1.92 RVU).

Building Block Approach (within perfusion family)

Multiple imaging session SPECT with WM/EF (new CPT code 78452) is more intensity and work than single session acquisition (new CPT code 78451). SPECT is more datasets and complexity than planar imaging (new CPT code 78453, for single planar; new CPT code 78454, for multiple planar). As such, 78452 is among the most complex nuclear cardiology/ nuclear medicine codes. Multiple image SPECT Perfusion has always been about 0.40 RVU greater than single session SPECT.

SERVICES REPORTED WITH MULTIPLE 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. Multiple studies may be at rest, with stress or redistribution. If performed with stress the appropriate stress code is billed separately in addition to the appropriate procedure code. It is common for multiple physicians to be involved in this procedure, cardiologists, radiologists and nuclear medicine physicians are the most common.

Table 1

Source: 2006 SAF 5% Carrier FileNational Estimate - 20 times the numbers generated above from the 5% file For low volume procedures or combinations. These National Estimates may be particularly unreliable.

	93015	93016	93017	93018	Performed Alone	Combination of more than 2 codes
78460	40	60	20	60	6,160	500
78461	1,020	120	-	120	25,080	2,460
78464	18,500	260	380	1,760	60,680	7,860
78465	1,432,240	14,080	41,780	91,580	1,441,860	374,100
78481	18,140	140	580	1,000	16,840	2,140
78483	14,520	80	40	740	8,780	560
Alone	899,920	1,000,220	113,640	1,125,940		

	Global	RVU	Pre	Intra	Post
93015	XXX	0.75	2	15	4
93016	XXX	0.45	10	38	10
93017	XXX	0.00	0	0	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT 78465 often with 78478 and/or 78480
In 2006 utilization for 78465 was 3,019,646 global and 1,286,235 professional.

Physician Breakdown For Professional Billings

49.28 %	CARDIOLOGY
35.87 %	DIAGNOSTIC RADIOLOGY
7.53 %	NUCLEAR MEDICINE
4.47 %	INTERNAL MEDICINE
0.93 %	INTERVENTIONAL RADIOLOGY
0.46 %	PATHOLOGY

Physician Breakdown For Global Billings

87.72 %	CARDIOLOGY
6.45 %	INTERNAL MEDICINE
1.72 %	DIAGNOSTIC RADIOLOGY
1.60 %	NUCLEAR MEDICINE
1.03 %	INDEPENDENT DIAGNOSTIC TESTING FACILITY
0.43 %	FAMILY PRACTICE

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 Nuclear Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 600000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Double the Medicare billables. See 2006 reakdown noted above.

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? 3,000,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. See 2006 reakdown noted above.

Specialty Frequency 0 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? No

If no, please select another crosswalk and provide a brief rationale. Recommend CPT 78465; this code represents the current PLI for MPI inherent in 78452. The PLI RVU for the TC component should be 0.00

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:78453 Tracking Number Specialty Society Recommended RVU: **1.00**

Global Period: XXX RUC Recommended RVU: **1.00**

CPT Descriptor: Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63- year-old female with hypertension and hypercholesterolemia has been experiencing chest discomfort and shortness of breath. She has significant arthritis of her upper extremities and back and difficulty with positioning when lying down. Resting electrocardiogram shows sinus rhythm and non-specific ST-T wave abnormalities. She is referred for stress myocardial perfusion study, which if completely normal will not require a rest study.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician determines the appropriateness of the requested study; prescribes, oversees and directs the intravenously administered dose. The physician directs the technologist to adjust the acquisition protocol as necessary for the individual patient. If wall motion and/or ejection fraction are performed, the physician assesses the patient's cardiac rhythm, directs the technologist in lead placement for optimal gating signal and any necessary adjustments in gating acquisition parameters based on individual rhythm assessment. The physician is available to answer questions for the technologist and to review components of the study throughout the study.

Description of Intra-Service Work: The study consists of a single study acquisition of either a stress or rest set of planar images, synchronized (gated) to the patient's electrocardiogram when performed. The physician verifies the completeness and adequacy of the data before completion of the study and may order additional imaging if necessary.

The planar images are reviewed for artifacts and abnormal extracardiac distribution. The cardiac images, that are acquired in at least three different projections (e.g. anterior, LAO and lateral), are reviewed. The physician compares the acquisition datasets for differences or similarities that would suggest ischemia or scar. Qualitative assessment of myocardial perfusion is made in a standardized manner, with each segment scored on a semi-quantitative scale.

Qualitative assessment of left ventricular global function is made, when performed. Wall motion is qualitatively scored for motion and thickening, when performed. This occurs in a standardized segment model for each dataset with each segment scored as normal, mildly hypokinetic, moderately hypokinetic, severely hypokinetic, akinetic, or dyskinetic. Attention is paid to the assessment of regional myocardial function and to the percent of myocardium that is regionally dysfunctional in order to judge the amount of underlying myocardial scar (or stress induced ischemia). The extent and severity of perfusion defects and their relationship to vascular geographic territories are noted.

When performed, wall motion and thickening quantitative data are generated and reviewed for the image set. The segmental wall motion data are compared to the perfusion images to generate a clinically relevant wall motion analysis for the individual patient. When performed, the left ventricular ejection fraction is noted after confirming the correctness of the regions of interest that were selected for the calculation. Digital data of perfusion and ventricular function are reviewed after the qualitative assessment, in part to refine the qualitative impression. Comparison to relevant prior studies is done. A report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician throughout the procedure provides regulatory review and oversight.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	Drs. Van Decker, McKusick, McGinty, Dillehay				
Specialty(s):	ACC, ACNP, ACR, ASNC, SNM				
CPT Code:	78453				
Sample Size:	741	**Resp N:**	69	**Response:** 9.3 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	30.00	1000.00
Survey RVW:	0.50	1.00	**1.35**	1.50	2.38
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**15.00**	20.00	55.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	78453	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
78472	XXX	0.98	**CMS Time File**

CPT Descriptor Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78306	XXX	0.86	**RUC Time**	581,384

CPT Descriptor 1 Bone and/or joint imaging; whole body

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78315	XXX	1.02	**RUC Time**	119,974

CPT Descriptor 2 Bone and/or joint imaging; three phase study

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 36.2 %

TIME ESTIMATES (Median)	CPT Code: 78453	Key Reference CPT Code: 78472	Source of Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	10.00	23.00	
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	**20.00**	**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	3.56	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.48
Urgency of medical decision making	3.44	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.64	3.44
Physical effort required	2.36	2.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.28	3.08
Outcome depends on the skill and judgment of physician	4.08	3.92
Estimated risk of malpractice suit with poor outcome	3.40	3.16

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.20	3.12
Intra-Service intensity/complexity	3.72	3.60
Post-Service intensity/complexity	3.04	3.04

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 Society of Nuclear Medicine, American College of Nuclear Physicians, American College of Cardiology, American College of Radiology and the Society of Nuclear Cardiology convened a consensus expert panel to review the random sample AMA RUC survey summary data from the professional societies. The panel notes this code represents a combination of previous codes.

Survey Results

The panel notes that the median survey RVU was 1.35 with a 75th percentile of 1.50 and a 25th percentile of 1.00. While the median is a slight decrease from the previous work of planar imaging plus assessment of wall motion and ejection fraction (WM/EF) (1.66 for the combined RVU of the 3 codes), in this new code, the panel expressed concern that the median value created "relative work rank order anomalies" with the surveyed family of codes for SPECT perfusion with WM/EF. The reference code was more reflective of simpler single session planar imaging (although intensities were judged higher). As such, the panel felt a recommendation of the 25th percentile of 1.00 was most appropriate.

Comparison to the Most Frequently Chosen Code

The panel compared 78453 to the most frequently chosen reference code 78472. 78472 is a robust planar method to obtain cardiac ventricular function and especially left ventricular wall motion and ejection fraction but provides no myocardial perfusion information. Respondents felt intensity/complexity of 78453 was greater than 78472, as well. Despite this, the panel felt that 78453 was in the category of the other similar codes in this work/intensity range and should serve as the starting building block for the planar and SPECT myocardial perfusion family. As such, a recommendation of 1.00 (25th percentile) appeared most accurate.

Comparison to Similar Codes

Single session planar bone imaging, 78306 – RVU 0.86 – has similar times and acquisition parameters but is without acquisition and interpretation of additional organ/system functional datasets (such as WM/EF). Three Phase bone imaging, 78315 – RVU 1.02 – has similar times and some additional simple temporal acquisition of "functionality". The panel felt this supported a recommendation of 1.00 for 78453.

Building Block Approach (within perfusion family)

Single session (rest or stress) planar imaging with WM/EF (new CPT code 78453, proposed RVU of 1.00) is the least complex of this new myocardial perfusion family. Multiple (rest and stress) planar imaging with WM/EF (new CPT code 78454) is more work and complexity, single session perfusion SPECT with wall motion/EF (new CPT code 78451) requires yet more effort and is of greater complexity that the previous two studies, and the most complex and requiring the greatest work is multiple session SPECT perfusion imaging with WM/EF (new CPT code 78452). The amount of work in 78453 is still at least as much work and complexity as other similar planar nuclear medicine codes, and the panel felt this supported a recommendation of 1.00 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. Single studies may be at rest or with stress. If performed with stress the appropriate stress code is billed separately in addition to the appropriate procedure code. It is common for multiple physicians to be involved in this procedure, cardiologists, radiologists and nuclear medicine physicians are the most common.

   Table 1

   Source: 2006 SAF 5% Carrier FileNational Estimate - 20 times the numbers generated above from the

5% file For low volume procedures or combinations. These National Estimates may be particularly unreliable.

Combination of more than	93015	93016	93017	93018	Performed Alone
2 codes 78460	40	60	20	60	6,160
500 78461	1,020	120	-	120	25,080
2,460 78464	18,500	260	380	1,760	60,680
7,860 78465	1,432,240	14,080	41,780	91,580	1,441,860
374,100 78481	18,140	140	580	1,000	16,840
2,140 78483	14,520	80	40	740	8,780
560 Alone	899,920	1,000,220	113,640	1,125,940	

	Global	RVU	Pre	Intra	Post
93015	XXX	0.75	2	15	4
93016	XXX	0.45	10	38	10
93017	XXX	0.00	0	0	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT 78460 sometimes with 78478 and/or 78480
In 2006 utilization for 78460 was 5,053 Global 4,978 professional.

Physician Breakdown For Professional Billings

76.86 %	DIAGNOSTIC RADIOLOGY
8.76 %	CARDIOLOGY
6.29 %	INTERNAL MEDICINE
2.81 %	NUCLEAR MEDICINE
2.39 %	INTERVENTIONAL RADIOLOGY
1.47 %	FAMILY PRACTICE

Physician Breakdown For Global Billings

45.33 %	CARDIOLOGY
28.00 %	INTERNAL MEDICINE
18.67 %	DIAGNOSTIC RADIOLOGY
5.33 %	NUCLEAR MEDICINE
2.67 %	INDEPENDENT DIAGNOSTIC TESTING FACILITY

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 Nuclear Medicine How often? Commonly

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. See 2006 breakdown noted above.

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. See CPT 78460 2006 breakdown noted above.

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. Recommend CPT 78460; this code represents the current PLI for MPI inherent in 78453. The PLI RVU for the TC component should be 0.00

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:78454 Tracking Number Specialty Society Recommended RVU: **1.34**

Global Period: XXX RUC Recommended RVU: **1.34**

CPT Descriptor: Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old male with cigarette use and hypertension has been experiencing chest pain and shortness of breath. He has significant arthritis and difficulty with positioning when lying down. Resting electrocardiogram shows sinus rhythm and non-specific ST-T wave abnormalities. He is referred for stress myocardial perfusion study.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform a E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician determines the appropriateness of the requested study; prescribes, oversees and directs the intravenously administered dose. The physician directs the technologist to adjust the acquisition protocol as necessary for the individual patient. If wall motion and/or ejection fraction are performed, the physician assesses the patient's cardiac rhythm, directs the technologist in lead placement for optimal gating signal and any necessary adjustments in gating acquisition parameters based on individual rhythm assessment. The physician is available to answer questions for the technologist and to review components of the study throughout the study.

Description of Intra-Service Work: The study consists of acquisition of both stress and rest (or redistribution) planar image sets, synchronized (gated) to the patient's electrocardiogram when performed. The physician verifies the completeness and adequacy of the images before completion of the study and may order additional imaging if necessary.

The planar images are reviewed for artifacts and abnormal extracardiac distribution. The cardiac images, that a acquired in at least three different projections (e.g. anterior, LAO and lateral) for both rest and stress sets of images, are reviewed. The physician compares the acquisition datasets for differences or similarities that would suggest ischemia or scar. Qualitative assessment of myocardial perfusion is made in a standardized manner, with each segment scored on a semi-quantitative scale. Qualitative assessment of left ventricular global function is made, when performed. Wall motion

is qualitatively scored for motion and thickening, when performed. This occurs in a standardized segment model for each dataset with each segment scored as normal, mildly hypokinetic, moderately hypokinetic, severely hypokinetic, akinetic, or dyskinetic. Attention is paid to the assessment of regional myocardial function and to the percent of myocardium that is regionally dysfunctional in order to judge the amount of underlying myocardial scar (or stress induced ischemia). The extent and severity of perfusion defects and their relationship to vascular geographic territories are noted.

When performed, wall motion and thickening quantitative data are generated and reviewed for the image set. The segmental wall motion data are compared to the perfusion images to generate a clinically relevant wall motion analysis for the individual patient. When performed, the left ventricular ejection fraction is noted after confirming the correctness of the regions of interest that were selected for the calculation. Digital data of perfusion and ventricular function are reviewed after the qualitative assessment, in part to refine the qualitative impression. Comparison to relevant prior studies is done. A report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician throughout the procedure provides regulatory review and oversight.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	Drs. Van Decker, McKusick, McGinty, Dillehay				
Specialty(s):	ACC, ACNP, ACR, ASNC, SNM				
CPT Code:	78454				
Sample Size:	742	**Resp N:**	68	**Response:** 9.1 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	50.00	2000.00
Survey RVW:	0.80	1.34	**1.50**	1.87	2.60
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	25.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	78454	**Recommended Physician Work RVU: 1.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
78473	XXX	1.47	**CMS Time File**

CPT Descriptor Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78707	XXX	0.96	**RUC Time**	32,439

CPT Descriptor 1 Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	580,439

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

)ther Reference CPT Code	Global	Work RVU	Time Source
/8709	XXX	1.41	**RUC Time**

CPT Descriptor Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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: 78454	Key Reference CPT Code: 78473	Source of Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	15.00	33.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
:dian 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	**25.00**	**33.00**	

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	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.58
Urgency of medical decision making	4.04	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.27	4.04
Physical effort required	2.73	2.69

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.62	3.42
Outcome depends on the skill and judgment of physician	4.38	4.15
Estimated risk of malpractice suit with poor outcome	3.85	3.69

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.46	3.31
Intra-Service intensity/complexity	4.25	4.08
Post-Service intensity/complexity	3.23	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 Val: Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine, American College of Nuclear Physicians, American College of Cardiology, American College of Radiology and the American Society of Nuclear Cardiology convened a consensus expert panel to review the random sample AMA RUC survey summary from the professional societies. The panel notes that the new code represents a combination of codes.

Survey results:

The panel notes that the median RVU of the survey was 1.50 with a 75th percentile of 1.87 and a 25th percentile of 1.34. While the median is a slight decrease from the previous work of planar imaging plus assessment of wall motion and ejection fraction (WM/EF) (2.03 for the combined RVU of the three codes) in this new code, the panel expressed concern that the median value could create "relative work rank order anomalies" with the SPECT perfusion codes with WM/EF. The reference code was more reflective of simpler (but multiple session) planar imaging. As such, the panel felt a recommendation of the 25th percentile of 1.34 was most appropriate.

Comparison to Most Frequently Chosen Code.

The panel compared 78454 with the most frequently chosen reference code of 78473 – RVU 1.47. 78473 is a planar study, consisting of multiple (rest/stress) acquisition datasets to obtain cardiac ventricular function and especially left ventricular wall motion/ejection fraction (essentially multiple 78472's) but yields no myocardial perfusion information. Respondents felt the intensity/complexity of 78454 was greater than 78473, as well. Despite this, the panel felt that 78454 was in the category of other similar multiple planar nuclear medicine codes and less than the work involved in single acquisition SPECT with EF/WM, the next code in the myocardial perfusion family of codes. As such, a recommendation of the 25th percentile of 1.34 appeared accurate.

Comparison to "Similar Codes"

CPT 78707, multiple session planar renal imaging with vascular flow/function, has some comparability in work and complexity to 78454. It has an RVU value of 1.41. In comparison to CPT 78707, the panel felt that a recommendation of 1.34 RVU at the 25 percentile was rational.

Building Block Approach (within perfusion family)

Multiple session (stress and rest) planar perfusion imaging with EF/WM (new CPT code 78454, proposed RVU of 1.34) is more work and complexity than single session planar perfusion imaging with EF/WM (new CPT code 78453, proposed RVU of 1.00). The service is less work and complexity than the SPECT myocardial perfusion studies (new CPT code 78451for single SPECT; new CPT code 78452, for multiple SPECT). The difference between the single planar and multiple planar perfusion studies has traditionally been about 0.40 RVU, suggesting a recommendation of at least 1.34 RVU is rational.

SERVICES REPORTED WITH MULTIPLE 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. Multiple studies may be at rest, with stress or redistribution. If performed with stress the appropriate stress code is billed separately in addition to the appropriate procedure code. It is common for multiple physicians to be involved in this procedure, cardiologists, radiologists and nuclear medicine physicians are the most common. Table 1

Source: 2006 SAF 5% Carrier FileNational Estimate - 20 times the numbers generated above from the 5% file For low volume procedures or combinations. These National Estimates may be particularly unreliable.

Performed Alone	Combination of more than 2 codes		93015	93016	93017	93018
6,160	500	78461	1,020	120	-	120
25,080	2,460	78464	18,500	260	380	1,760
60,680	7,860	78465	1,432,240	14,080	41,780	91,580
1,441,860	374,100	78481	18,140	140	580	1,000
16,840	2,140	78483	14,520	80	40	740
8,780	560	Alone	899,920	1,000,220	113,640	1,125,940

Post		Global	RVU	Pre	Intra
4	93015	XXX	0.75	2	15
10	93016	XXX	0.45	10	38
0	93017	XXX	0.00	0	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT 78461 sometimes with 78478 and/or 78480
In 2006 utilization for 78461 was 23,905 global and 23,694 professional.

Physician Breakdown For Professional Billings

81.39 %	DIAGNOSTIC RADIOLOGY
10.46 %	CARDIOLOGY
3.19 %	NUCLEAR MEDICINE
2.95 %	INTERNAL MEDICINE
1.00 %	INTERVENTIONAL RADIOLOGY
0.29 %	PEDIATRIC MEDICINE

Physician Breakdown For Global Billings

34.12 %	CARDIOLOGY
27.96 %	DIAGNOSTIC RADIOLOGY
25.12 %	NUCLEAR MEDICINE
9.00 %	INTERNAL MEDICINE
1.42 %	FAMILY PRACTICE
0.95 %	RADIATION ONCOLOGY

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 Nuclear Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 48000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. See 2006 breakdown noted above.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
;pecialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 CMS data base. See breakdown noted above.

Specialty	Frequency	Percentage	%
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? No

If no, please select another crosswalk and provide a brief rationale. Recommend CPT 78461; this code represents the current PLI for MPI inherent in 78454. The PLI RVU for the TC component should be 0.00

ndicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The five societies performing this service, the American College of Cardiology (ACC), the American College of Nuclear Physicians (ACNP), the American College of Radiology (ACR), the American Society of Nuclear Cardiology (ASNC), and the Society of Nuclear Medicine (SNM) utilized current AMA and CMS PE approved inputs to develop the direct practice expense recommendations for code 78451. We then compared the inputs to surveys from society members and consensus panel to further develop the practice expense recommendations. Attention was paid to the geographic distribution and practice type (private practice) for the input from society member and consensus panel. A joint consensus between ACC, ACNP, ACR, ASNC and SNM was reached for the final practice expense recommendation for this code. Input from the specialty society members was used to establish current techniques and the common service times for various work elements that were provided to the consensus committee.

Finally, we note that since this service may be accompanied by a stress test (either exercise or pharmacologic) that is billed separately. Thus, all resources associated with the stress test have been excluded.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The nuclear medicine technologist (NMT) confirms the test order with the physician regarding technique and radiopharmaceutical to be used, making any necessary changes from the usual protocol based upon the patient's particular history and/or present condition. The NMT at the direction of the physician orders, receives the package containing radioactive material performing a radiation survey for radioactive contamination, organizes and prepares the radiopharmaceutical for administration to the patient. The NMT prepares the room, equipment and collimation for the patient imaging study.

The NMT performs a daily camera assessment including daily floods, recalibration, energy peak check for different isotopes used for this procedure; weekly/monthly/quarterly assessment of camera uniformity, center of rotation and resolution studies to include periodic maintenance as dictated by the test performed on the nuclear medicine camera and computer in preparation for quality tomographic nuclear medicine imaging.

Intra-Service Clinical Labor Activities:

Before beginning the procedure, the NMT reviews the indicated procedure and the radiation risks with the patient, answering the patient's questions. The NMT obtains the patient's history evaluating contraindications such as pregnancy or claustrophobia. The NMT prepares the patient with proper insertion of the IV, stopcock and extension tubing; when gating is performed, ECG electrodes are applied, insuring good contact and a reliable computer signal for gating or triggering. Electrodes are re-arranged for optimal signal. Suitability of gating or triggering is assessed. The NMT assays the patient radiopharmaceutical dose, recording the dose in appropriate NRC records, patient medical records and computer procedure protocols. When performed the NMT stands by during the stress/exercise procedure to inject the radiopharmaceutical (at the direction of the supervising physician or qualified designate) at near peak stress. Exercise is continued for at least one minute post-injection. Termination of stress/exercise is individual patient-specific and at the direction of the supervising physician or qualified designate.

The NMT positions the patient on the nuclear medicine imaging table, positions the camera defining the circuit of motion of camera around the patient, defines computer acquisition parameters and acquires the required diagnostic imaging set. When performed the camera is set up to collect attenuation correction images utilizing computed tomography or gadolinium rods. The NMT monitors the patient during acquisition for possible motion, comfort, and clinical safety. The NMT inspects the imaging set to ensure accurate positioning and placement in addition to appropriate target to background organ isolation before the procedure is completed. The quality of functional ECG gated imaging is assessed and adjustments/reacquisition performed as necessary.

The NMT then quantitatively processes all acquired imaging data for review by the interpreting physician, including qualitative and quantitative data (both pre and post attenuation data sets). The raw perfusion images are processed separately from the attenuation correction images, when

performed. The gated SPECT study is processed separately from the perfusion images. Regions of interest are established for ejection fraction calculations. Any pertinent anomalies that occurred during the procedure are noted and reviewed later with the reading physician.

Upon completion of imaging, the NMT removes the patient IV and dismisses the patient with after-care instructions and any additional education regarding radiation safety in the home and general public environment. The dismissal instructions must include counseling on precautions to reduce radiation exposure to the public, friends, and family members.

The NMT cleans all rooms utilized during the procedure, including the injection area, stress and scan rooms. The NM appropriately stores and disposes of all radioactive contaminated materials, including syringes, needles, IV sets, disposable peripheral materials (such as bed linens, clothing, gauze, tapes, and chux padding) following Nuclear Regulatory Commission guidelines and regulations. The NMT archives each new patient data set.

Post-Service Clinical Labor Activities:

The NMT displays the images for the interpreting physician's review including placing on the physician's view box or reading station, printing images, retrieving and displaying prior studies and obtaining archived data on other related procedures and/or laboratory results.

The NMT completes all nuclear regulatory compliance procedures as related to this technology such as daily wipe testing with radiation counting of each wipe, radiation monitoring of the hot lab, camera room and stress testing areas; personal hand and foot monitoring; disposing of biohazard of all appropriately decayed radiation supplies defacing labels when appropriate; assessing constancy of the dose calibrator, allocation and discussing results with appropriate staff members. Each radiation compliance action requires documentation and recording of the given task as per the Nuclear Regulatory Commission guidelines and regulations.

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

46AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The five societies performing this service, the American College of Cardiology (ACC), the American College of Nuclear Physicians (ACNP), the American College of Radiology (ACR), the American Society of Nuclear Cardiology (ASNC), and the Society of Nuclear Medicine (SNM) utilized current AMA and CMS PE approved inputs to develop the direct practice expense recommendations for code 78452. We then compared the inputs to surveys from society members and consensus panel to further develop the practice expense recommendations. Attention was paid to the geographic distribution and practice type (private practice) for the input from society member and consensus panel. A joint consensus between ACC, ACNP, ACR, ASNC and SNM was reached for the final practice expense recommendation for this code. Input from the specialty society members was used to establish current techniques and the common service times for various work elements that were provided to the consensus committee.

Finally, we note that since this service may be accompanied by a stress test (either exercise or pharmacologic) that is billed separately. Thus, all resources associated with the stress test have been excluded.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The nuclear medicine technologist (NMT) confirms the test order with the physician regarding technique and radiopharmaceutical to be used, making any necessary changes from the usual protocol based upon the patient's particular history and/or present condition. The NMT at the direction of the physician orders, receives the package containing radioactive material performing a radiation survey for radioactive contamination, organizes and prepares the radiopharmaceutical for administration to the patient. The NMT prepares the room, equipment and collimation for the patient imaging study.

The NMT performs a daily camera assessment including daily floods, recalibration, energy peak check for different isotopes used for this procedure; weekly/monthly/quarterly assessment of camera uniformity, center of rotation and resolution studies to include periodic maintenance as dictated by the test performed on the nuclear medicine camera and computer in preparation for quality tomographic nuclear medicine imaging.

Intra-Service Clinical Labor Activities:

Before beginning the procedure, the NMT reviews the indicated procedure and the radiation risks with the patient, answering the patient's questions. The NMT obtains the patient's history evaluating contraindications such as pregnancy or claustrophobia. The NMT prepares the patient with proper insertion of the IV, stopcock and extension tubing; when gating is performed, ECG electrodes are applied, insuring good contact and a reliable computer signal for gating or triggering. Electrodes are re-arranged for optimal signal. Suitability of gating or triggering is assessed. The NMT assays the patient radiopharmaceutical dose, recording the dose in appropriate NRC records, patient medical records and computer procedure protocols. When performed the NMT stands by during the stress/exercise procedure to inject the radiopharmaceutical (at the direction of the supervising physician or qualified designate) at near peak stress. Exercise is continued for at least one minute post-injection. Termination of stress/exercise is individual patient-specific and at the direction of the supervising physician or qualified designate.

The NMT positions the patient on the nuclear medicine imaging table, positions the camera defining the circuit of motion of camera around the patient, defines computer acquisition parameters and acquires the required diagnostic imaging set. When performed the camera is set up to collect attenuation correction images utilizing computed tomography or gadolinium rods. The NMT monitors the patient during acquisition for possible motion, comfort, and clinical safety. The NMT inspects the imaging set to ensure accurate positioning and placement in addition to appropriate target to background organ isolation before the procedure is completed. The quality of functional ECG gated imaging is assessed and adjustments/reacquisition performed as necessary.

The NMT then quantitatively processes all acquired imaging data for review by the interpreting physician, including qualitative and quantitative data (both pre and post attenuation data sets). The raw perfusion images are processed separately from the attenuation correction images, when performed. The gated SPECT study is processed separately from the perfusion images. Regions of interest are established for ejection fraction calculations. Any pertinent anomalies that occurred during the procedure are noted and reviewed later with the reading physician.

Upon completion of the first diagnostic imaging set (in this case the stress procedure) the patient is given instructions regarding the second diagnostic rest imaging set and also instructed on the appropriate time to return for completion of the procedure. The patient's activity and diet restrictions are reviewed in detail if radiopharmaceutical and protocol stipulates. All questions regarding radiation safety are again answered before patient's departure.
The NMT cleans all rooms utilized during the procedure, including the injection area, stress and scan rooms. The NM appropriately stores and disposes of all radioactive contaminated materials, including syringes, needles, IV sets, disposable peripheral materials (such as bed linens, clothing, gauze, tapes, and chux padding) following Nuclear Regulatory Commission guidelines and regulations.

Upon returning for the second resting diagnostic imaging set, the NMT again prepares, assays, records and delivers the prescribed radiopharmaceutical when appropriate following physician approved protocol. If a second injection of a radiopharmaceutical occurs, administration is via the patient IV setup from the initial procedure. IV is first tested and flushed to ensure patency. The patient is again positioned and imaged by the NMT, repeating the same positioning and

placement as the initial acquisition. The patient is again monitored carefully for optimal image acquisition. The second (rest or redistribution) diagnostic imaging set is inspected.

Upon completion of this second set of imaging, the NMT removes the patient's IV and dismisses the patient with after-care instructions and any additional education regarding radiation safety in the home and general public environment. The dismissal instructions must include answering any questions on precautions to reduce radiation exposure to the public, friends, and family members

This second set of image acquisition and processing is completed as noted previously for the initial image set.

The room must again be cleaned prior to the next patient procedure, removing and disposing any patient-specific materials in preparation as noted in the first image set following Nuclear Regulatory Commission guidelines and regulations. The NMT archives each new patient data set.

Post-Service Clinical Labor Activities:

The NMT displays the images for the interpreting physician's review including placing on the physician's view box or reading station, printing images, retrieving and displaying prior studies and obtaining archived data on other related procedures and/or laboratory results.

The NMT completes all nuclear regulatory compliance procedures as related to this technology such as daily wipe testing with radiation counting of each wipe, radiation monitoring of the hot lab, camera room and stress testing areas; personal hand and foot monitoring; disposing of biohazard of all appropriately decayed radiation supplies defacing labels when appropriate; assessing constancy of the dose calibrator, allocation and discussing results with appropriate staff members. Each radiation compliance action requires documentation and recording of the given task as per the Nuclear Regulatory Commission guidelines and regulations.

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The five societies performing this service, the American College of Cardiology (ACC), the American College of Nuclear Physicians (ACNP), the American College of Radiology (ACR), the American Society of Nuclear Cardiology (ASNC), and the Society of Nuclear Medicine (SNM) utilized current AMA and CMS PE approved inputs to develop the direct practice expense recommendations for code 78453. We then compared the inputs to surveys from society members and consensus panel to further develop the practice expense recommendations. Attention was paid to the geographic distribution and practice type (private practice) for the input from society member and consensus panel. A joint consensus between ACC, ACNP, ACR, ASNC and SNM was reached for the final practice expense recommendation for this code. Input from the specialty society members was used to establish current techniques and the common service times for various work elements that were provided to the consensus committee.

Finally, we note that since this service may be accompanied by a stress test (either exercise or pharmacologic) that is billed separately. Thus, all resources associated with the stress test have been excluded.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The nuclear medicine technologist (NMT) confirms the test order with the physician regarding technique and radiopharmaceutical to be used, making any necessary changes from the usual protocol based upon the patient's particular history and/or present condition. The NMT at the direction of the physician orders, receives the package containing radioactive material performing a radiation survey for radioactive contamination, organizes and prepares the radiopharmaceutical for administration to the patient. The NMT prepares the room, equipment and collimation for the patient imaging study. The NMT performs a daily camera assessment including daily floods, recalibration, energy peak check for isotopes used for this procedure; and weekly/monthly/quarterly assessment of camera uniformity and resolution studies to include periodic maintenance as dictated by the test performed on the nuclear medicine camera and computer in preparation for quality planar nuclear medicine imaging.

Intra-Service Clinical Labor Activities:

Before beginning the procedure, the NMT reviews the indicated procedure and the radiation risks with the patient, answering the patient's questions. The NMT obtains the patient's history evaluating contraindications such as pregnancy or claustrophobia. The NMT prepares the patient with proper insertion of the IV, stopcock and extension tubing; when gating is performed, ECG electrodes are applied, insuring good contact and a reliable computer signal for gating or triggering. Electrodes are re-arranged for optimal signal. Suitability of gating or triggering is assessed. The NMT assays the patient radiopharmaceutical dose, recording the dose in appropriate NRC records, patient medical records and computer procedure protocols. When performed the NMT stands by during the stress/exercise procedure to inject the radiopharmaceutical (at the direction of the supervising physician or qualified designate) at near peak stress. Exercise is continued for at least one minute post-injection. Termination of stress/exercise is individual patient-specific and at the direction of the supervising physician or qualified designate.

The NMT positions the patient on the nuclear medicine imaging table, positions the camera and acquires a minimum of three planar images (e.g. anterior, LAO and lateral). The NMT monitors the patient during acquisition for possible motion, comfort, and clinical safety. The NMT inspects the imaging set to ensure accurate positioning and placement in addition to appropriate target to background organ isolation before the procedure is completed. The quality of functional ECG gated imaging is assessed and adjustments/reacquisition performed as necessary. Regions of interest are established for ejection fraction calculations when performed. Any pertinent anomalies that occurred during the procedure are noted and reviewed later with the reading physician.

Upon completion of imaging, the NMT removes the patient IV and dismisses the patient with after-care instructions and any additional education regarding radiation safety in the home and general public environment. The dismissal instructions must include counseling on precautions to reduce radiation exposure to the public, friends, and family members.

The NMT cleans all rooms utilized during the procedure including the injection area, stress and scan rooms. The NM appropriately stores and disposes of all radioactive contaminated materials, including syringes, needles, IV sets, disposable peripheral materials (such as bed linens, clothing, gauze, tapes, and chux padding) following Nuclear Regulatory Commission guidelines and regulations. The NMT archives each new patient data set.

Post-Service Clinical Labor Activities:

The NMT displays the images for the interpreting physician's review including placing on the physician's view box or reading station, printing images, retrieving and displaying prior studies and obtaining archived data on other related procedures and/or laboratory results.

The NMT completes all nuclear regulatory compliance procedures as related to this technology such as daily wipe testing with radiation counting of each wipe, radiation monitoring of the hot lab, camera room and stress testing areas; personal hand and foot monitoring; disposing of biohazard of all appropriately decayed radiation supplies defacing labels when appropriate; assessing constancy of the dose calibrator, allocation and discussing results with appropriate staff members. Each radiation compliance action requires documentation and recording of the given task as per the Nuclear Regulatory Commission guidelines and regulations.

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The five societies performing this service, the American College of Cardiology (ACC), the American College of Nuclear Physicians (ACNP), the American College of Radiology (ACR), the American Society of Nuclear Cardiology (ASNC), and the Society of Nuclear Medicine (SNM) utilized current AMA and CMS PE approved inputs to develop the direct practice expense recommendations for code 78454. We then compared the inputs to surveys from society members and consensus panel to further develop the practice expense recommendations. Attention was paid to the geographic distribution and practice type (private practice) for the input from society member and consensus panel. A joint consensus between ACC, ACNP, ACR, ASNC and SNM was reached for the final practice expense recommendation for this code. Input from the specialty society members was used to establish current techniques and the common service times for various work elements that were provided to the consensus committee.

Finally, we note that since this service may be accompanied by a stress test (either exercise or pharmacologic) that is billed separately. Thus, all resources associated with the stress test have been excluded.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The nuclear medicine technologist (NMT) confirms the test order with the physician regarding technique and radiopharmaceutical to be used, making any necessary changes from the usual protocol based upon the patient's particular history and/or present condition. The NMT at the direction of the physician orders, receives the package containing radioactive material performing a radiation survey for radioactive contamination, organizes and prepares the radiopharmaceutical for administration to the patient. The NMT prepares the room, equipment and collimation for the patient imaging study. The NMT performs a daily camera assessment including daily floods, recalibration, energy peak check for isotopes used for this procedure; and weekly/monthly/quarterly assessment of camera uniformity and resolution studies to include periodic maintenance as dictated by the test performed on the nuclear medicine camera and computer in preparation for quality planar nuclear medicine imaging.

Intra-Service Clinical Labor Activities:

Before beginning the first procedure, the NMT reviews the indicated procedure and the radiation risks with the patient, answering the patient's questions. The NMT obtains the patient's history evaluating contraindications such as pregnancy or claustrophobia. The NMT prepares the patient with proper insertion of the IV, stopcock and extension tubing; when gating is performed, ECG electrodes are applied, insuring good contact and a reliable computer signal for gating or triggering. Electrodes are re-arranged for optimal signal. Suitability of gating or triggering is assessed. The NMT assays the patient radiopharmaceutical dose, recording the dose in appropriate NRC records, patient medical records and computer procedure protocols. When performed the NMT stands by during the stress/exercise procedure to inject the radiopharmaceutical (at the direction of the supervising physician or qualified designate) at near peak stress. Exercise is continued for at least one minute post-injection. Termination of stress/exercise is individual patient-specific and at the direction of the supervising physician or qualified designate.

The NMT positions the patient on the nuclear medicine imaging table, positions the camera and acquires a minimum of three planar images (e.g. anterior, LAO and lateral). The NMT monitors the patient during acquisition for possible motion, comfort, and clinical safety. The NMT inspects the imaging set to ensure accurate positioning and placement in addition to appropriate target to background organ isolation before the procedure is completed. The quality of functional ECG gated imaging is assessed and adjustments/reacquisition performed as necessary. Regions of interest are established for ejection fraction calculations when performed. Any pertinent anomalies that occurred during the procedure are noted and reviewed later with the reading physician.

Upon completion of the first diagnostic imaging set (in this case the stress procedure) the patient is given instructions regarding the second diagnostic rest imaging set and also instructed on the appropriate time to return for completion of the procedure. The patient's activity and diet restrictions are reviewed in detail if radiopharmaceutical and protocol stipulates. All questions

regarding radiation safety are again answered before patient's departure. The NMT cleans all rooms utilized during the procedure, including the injection area, stress and scan rooms. The NM appropriately stores and disposes of all radioactive contaminated materials, including syringes, needles, IV sets, disposable peripheral materials (such as bed linens, clothing, gauze, tapes, and chux padding) following Nuclear Regulatory Commission guidelines and regulations.

Upon return of the patient for the second resting diagnostic imaging set, the NMT again prepares, assays, records and delivers the prescribed radiopharmaceutical, when appropriate, following physician approved protocol. If a second injection of a radiopharmaceutical is ordered, administration is via the patient IV setup from the initial procedure. IV is first tested and flushed to ensure patency. The patient is again positioned and imaged by the NMT, repeating the same positioning and placement as the initial acquisition. The patient is again monitored carefully for optimal image acquisition. The second (rest or redistribution) diagnostic imaging set is inspected. The image acquisition and processing is completed as noted previously. The room must again be cleaned, removing and disposing any patient-specific materials in preparation as noted in the first image set, prior to the next patient procedure. The NMT archives each new patient data set.

Upon completion of imaging, the NMT removes the patient IV and dismisses the patient with after-care instructions and any additional education regarding radiation safety in the home and general public environment. The dismissal instructions must include counseling on precautions to reduce radiation exposure to the public, friends, and family members.

Post-Service Clinical Labor Activities:

The NMT displays the images (stress and rest or redistribution) for the interpreting physician's review including placing on the physician's view box or reading station, printing images, retrieving and displaying prior studies and obtaining archived data on other related procedures and/or laboratory results.

The NMT completes all nuclear regulatory compliance procedures as related to this technology such as daily wipe testing with radiation counting of each wipe, radiation monitoring of the hot lab, camera room and stress testing areas; personal hand and foot monitoring; disposing of biohazard of all appropriately decayed radiation supplies defacing labels when appropriate; assessing constancy of the dose calibrator, allocation and discussing results with appropriate staff members. Each radiation compliance action requires documentation and recording of the given task as per the Nuclear Regulatory Commission guidelines and regulations.

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

	A	B	C	D	E	F	G
1				78451	78452	78453	78454
2	**Meeting Date: January - February 2009**	CMS	Staff	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress(exercise or pharmacologic) and/or redistribution and/or rest reinjection
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**	L049A	NMT	133.0	187.0	121.0	168.0
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L049A	NMT	23.0	23.0	20.0	20.0
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L049A	NMT	99.0	150.0	90.0	134.0
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	L049A	NMT	11.0	14.0	11.0	14.0
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Review x-ray, lab and past test to confirm appropriantess with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutial dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	L049A	NMT	3	3	3	3
12	QC SPECT Equipment	L049A	NMT	7	7		
13	QC Planar Equipment	L049A	NMT			4	4
14	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injeciton with in-house labels and records.	L049A	NMT	13	13	13	13
15	**End: When patient enters office/facility for surgery/procedure**	L049A					
16	**SERVICE PERIOD**						
17	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
18	Greet patient and provide gowning	L049A	NMT	3	6	3	6
19	Review mandatory radiation education; verbal consent	L049A	NMT	3	3	3	3
20	Prepare room, equipment, supplies, change collimator and set up protocol	L049A	NMT	3	6	2	4
21	**Intra-service**	L049A					
22	Position patient/ monitor patient/ set up ECG per protocol, verify appropriate signal sufficient for imaging	L049A	NMT	9	14	7	10
23	Instruction/Counseling as patient is taken back to waiting area after each scanning session	L049A	NMT	3	6	3	6
24	Set up IV; tech present during stress test for injection of RP; repeat injection for rest/redistribution	L049A	NMT	19	24	19	24
25	Obtain RP from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	L049A	NMT	5	10	5	10
26	Acquire images and reivew for completeness and quality, and time	L049A	NMT	30	55	27	49
27	Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient	L049A	NMT	24	26	21	22
28	**Post-Service**	L049A					
29	Clean room/equipment by physician staff	L049A	NMT	3	6	3	6
30	Specific room clean up of RP injection areas with defacement of labels	L049A	NMT	5	5	5	5
31	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	L049A	NMT	3	3	3	3
32	**End: Patient leaves office**	L049A					
33	**POST-SERVICE P**						
34	**None**						

1623

	A	B	C	D	E	F	G
1				78451	78452	78453	78454
2	**Meeting Date: January - February 2009**	CMS	Staff	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress(exercise or pharmacologic) and/or redistribution and/or rest reinjection
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**	**Non Facility**
35	**MEDICAL SUPPLIES**		**Unit**				
36	drape, non-sterile, sheet 40in x 60in	SB006		1	2	1	2
37	underpad 2ft x 3ft (Chux)	SB044		1	4	1	2
38	angiocatheter 14g-24g	SC001		1	1	1	1
39	heparin lock	SC012		1	1	1	1
40	needle, 18-27g	SC029		1	2	1	2
41	stop cock, 3-way	SC049		1	1	1	1
42	syringe 10-12ml	SC051		1	1	1	2
43	sanitizing cloth-wipe (surface, instruments, equipment)	SM022		5	10	5	10
44	pack, minimum multi-specialty visit	SA048		1	2	1	2
45	film, x-ray 8in x 10in	SK037		2	4	2	4
46	x-ray developer solution	SK089		2	4	2	4
47	x-ray envelope	SK091		1	1	1	1
48	x-ray fixer solution	SK092		2	4	2	4
49	swab-pad, alcohol	SJ053		2	4	2	4
50	heparin lock flush soln	SH040		1	1	1	1
51	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068		1	2	1	2
52	bandage, strip 0.75in x 3in (Bandaid)	SG021		1	1	1	1
53	gauze, non-sterile 2in x 2in	SG050		1	2	1	2
54	**Equipment**						
55	dose calibration source vial set (Cs137, Co57, and Ba137)	ER026		1	1	1	1
56	dose calibrator (Atomlab)	ER027		1	1	1	1
57	gamma camera system, single-dual head	ER032		1	1	1	1
58	Gadolinium rod	ER044		2	2		
59	radiation L-block tabletop shield	ER053		1	1	1	1
60	radiation survey meter	ER054		1	1	1	1
61	safe, storage, lead-lined	ER058		1	1	1	1
62	x-ray view box, 4 panel	ER067		1	1	1	1
63	computer workstation, nuclear medicine analysis	ED019		1	1	1	1
64	computer workstation, nuclear pharmacy management (hardware and software)	ED020		1	1	1	1
65	Cobalt-57 Flood Source (47cm dia) (10 mCi)	ER001		1	1	1	1
66	ECG R-wave trigger (gating) device	EQ007		1	1	1	1
67	chair, medical recliner	EF009		1	1	1	1
68	Film processor, x-omat M6B	ED027		1	1	1	1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from Five-Year Review

April 2009

Bundled Audiology Tests

In February 2008, the RUC identified 92541, 92542, 92544, 92545, 92567, 92568, and 92569 through the Codes Reported Together screen as several pairings of these services are reported together more than 95% of the time. The RUC referred these codes to CPT for creation of new bundled services and to reorganize the coding structure to reflect the typical procedures performed.

92540
The RUC reviewed code 92540 *Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording* which bundles codes 92541, 92542, 92544 and 92545. Since the proposed RVUs were higher than the bundling of these four services the specialty societies were required to present compelling evidence. The RUC agreed that there was compelling evidence to warrant a higher work RVU because these services had never been RUC surveyed and audiologists' had not been included in the original Harvard study.

1626

The RUC reviewed the survey results for 92540 comprised of 66 respondents, (51 Audiologists, 10 Otolaryngologists and 5 Neurologists). The RUC compared 92540 to reference service *92557 Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60, 20 minutes intra-service) and agreed that 92540 is more than double the physician work and time than 92557. The RUC determined that the 60 minutes intra-service time for 92540 is appropriate as the health care provider performs a battery of four successive procedures, evaluation for spontaneous nystagmus, positional nystagmus testing, optokineticnystagmus testing and oscillating tracking. The RUC determined that 10 minutes of immediate post-service time is required to explain results from a functional and physiological perspective to a referring physician and the patient. The RUC agreed with the specialty society recommended physician times of pre-service time package 5 – Non-Facility Procedure without sedation/anesthesia 7 minutes, 60 minutes intra-service time and 10 minutes immediate post-service time. The RUC agreed with the survey median work RVU of 1.50, as it is representative of the audiologists' survey responses, who are the primary providers of this service. The recommended work RVU of 1.50 places this service in the proper rank order with other services provided by audiologists, as well as similar services provided by other health care professionals. For additional support the RUC compared 92540 to HCPAC MPC codes 97001 *Physical therapy evaluation* (work RVU = 1.20) and 90806 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility,*

approximately 45 to 50 minutes face-to-face with the patient (work RVU = 1.86). **The RUC recommends a work RVU of 1.50 for 92540.**

92570

The RUC reviewed code 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* which bundles codes 92567, 92568 and 92569. The specialty societies recommended a work RVU lower than these three combined services.

The RUC reviewed the survey results for 92570 in which 92 Audiologists and 6 Otolaryngologists responded. The RUC compared 92570 to reference service *92557 Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60, 20 minutes intra-service) and agreed that 92570 requires approximately the same amount of physician work and time as code 92557. The RUC agreed with the specialty society recommended physician times of pre-service time package 5 – Non-Facility Procedure without sedation/anesthesia minus 4 minutes (totaling 3 minutes) as the provider is primarily setting-up the patient to perform the tests; 15 minutes intra-service time, and 3 minutes immediate post-service time. The RUC agreed that the 92 Audiologist survey respondents median work RVU of 0.55 was appropriate, as 92570 requires 5 minutes less intra-service time than 92557. The recommended work RVU places this service in the proper rank order with other services provided by audiologists, as well as similar services provided by other health care professionals. For additional support the RUC compared 92570 to HCPAC MPC codes 97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* (work RVU = 0.44) and 97755 *Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes* (work RVU = 0.62). **The RUC recommends a work RVU of 0.55 for code 92570.**

1627

92550

The RUC reviewed code 92550 *Tympanometry and reflex threshold measurements* which bundles codes 92567 and 92568. The specialty societies recommended a work RVU lower than these two combined services.

The RUC reviewed the survey results for 92570 in which 94 Audiologists and Otolaryngologists responded. The RUC compared 92550 to reference service 92568 *Acoustic reflex testing; threshold* (work RVU = 0.29, 8 minutes intra-service) and agreed that 92550 requires approximately the same amount of physician work and time as code 92568. The RUC agreed with the specialty society recommended physician times of pre-service time package 5 – Non-Facility Procedure without sedation/anesthesia minus 4 minutes (totaling 3 minutes) as the provider is primarily setting-up the patient to perform the tests; 10 minutes intra-service time and 3 minutes immediate post-service time. The RUC agreed that survey 25th percentile work RVU of 0.35 was appropriate, as 92550 requires slightly more time to perform than 92568 alone. The recommended work RVU places this service in the proper rank order with other services provided by audiologists,

as well as similar services provided by other health care professionals. **The RUC recommends the survey 25th percentile work RVU of 0.35 for code 92550.**

Practice Expense
The RUC recommends that the Audiologists' clinical labor time for codes 92541-92545 be reduced to zero, as all Audiologist time is transitioning to the work component. Additionally, the RUC recommends no clinical labor time for 92540-92550.

PLI
The RUC recommends that 92540 be crosswalked to 92620 and codes 92570 and 92550 be crosswalked to 92621.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
92541		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording (Do not report 92541 when performed in conjunction with the set of 92542, 92544 and 92545)	XXX	0.40 (No Change)
92542		Positional nystagmus test, minimum of 4 positions, with recording (Do not report 92542 when performed in conjunction with the set of 92541, 92544 and 92545)	XXX	0.33 (No Change)
92543		Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording (Do not report 92541, 92542, or 92543, at the same session.)	XXX	0.10 (No Change)
92544		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (Do not report 92544 when performed in conjunction with 92541, 92542 and	XXX	0.26 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		92545)		
92545		Oscillating tracking test, with recording	XXX	0.23 (No Change)
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	XXX	0.60 (No Change)
92567		Tympanometry (impedance testing)	XXX	0.20 (No Change)
92568		Acoustic reflex testing; threshold	XXX	0.29 (No Change)
D 92569		~~Acoustic reflex testing; decay~~ (Code 92569 has been deleted. If this service is performed in conjunction with tympanometry, see code 92570.	XXX	N/A
●92540	JJ1	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording (Do not report 92540 in conjunction with 92541, 92542, 92544, or 92545)	XXX	1.50
●92570	JJ2	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing (Do not report 92570 in conjunction with 92567, 92568)	XXX	0.55
●92550	JJ3	Tympanometry and reflex threshold measurements (Do not report 925X3 in conjunction with 92567 or 92568)	XXX	0.35

1629

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92540 Tracking Number JJ1 Specialty Society Recommended RVU: **1.50**

Global Period: XXX RUC Recommended RVU: **1.50**

CPT Descriptor: Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokineticnystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording.

(Do not report 92540 in conjunction with 92541, 92542, 92544, or 92545)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old male presents with a three month history of spontaneous spells of incapacitating vertigo that last from 1-4 hours, occurring 1-2 times per month. He reports near simultaneous onset of fluctuating hearing loss on the left, vertigo, and left side tinnitus. He has a documented hearing loss in his left ear that varies over time.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

ercent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; ischarged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The pre-service work includes a chart review for evidence in previous testing, current medications, and entering the patient's demographic information into the recording computer.

Description of Intra-Service Work: The intra-service work begins with prepping the skin and applying electrodes that will record the nystagmus. After the electrodes are affixed to the skin with conducting gel or paste, they must be monitored for a short time to allow the impedance to stabilize. After the electrodes are applied and stabilized, calibration of the nystagmus must be performed by measuring the eye movements while tracking a light stimulus that moved across a predetermined arc to constitute a specified number of degrees in each direction. The health care ovider then proceeds to the test battery which consists of four successive procedures: evaluation for spontaneous ystagmus, positional nystagmus testing, optokineticnystagmus testing, and oscillating tracking.
Spontaneous nystagmus: The qualified health care professional monitors eye movements with a recording system while the patient views targets in the center and eccentric positions to the right, left, up and down. The monitoring is then repeated with the eyes in similar positions but with visual fixation removed.

Positional nystagmus testing: The qualified health care professional moves the patient into a series of specific positions while recording the eye movements that occur once the position is achieved. The number of positions varies but a minimum of 4 are routine.

Optokineticnystagmus testing: The qualified health care professional presents a large visual field stimulus typic[redacted] composed of stripes or random dots that are set into motion to generate an optokineticnystagmus that is recorded analyzed for the speed of the eye referenced to the speed of the target.

Oscillating tracking: The qualified health care professional records eye movements while the patient views a target that moves in the patient's visual field in a sinusoidal oscillatory profile.

Perform the calculations necessary to determine magnitude and direction of nystagmus under each test condition, reviewing the data to ensure the absence of artifact that could adversely influence the results and interpretation, printing the nystagmus recordings for archival documentation, preparing a report of the diagnostic results and interpretation.

Description of Post-Service Work: Post-service work includes describing the results to the patient and notifying the referring physician of the test outcomes.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009					
Presenter(s):	Robert C Fifer, PhD, Kadyn Williams, AuD, Jane Dillon, MD, Gregory L. Barkley, MD					
Specialty(s):	Audiology, Neurology, Otolaryngology					
CPT Code:	92540					
Sample Size:	267	**Resp N:**	66	**Response:** 24.7 %		
Sample Type:	Convenience					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	17.50	**62.50**	150.00	750.00
Survey RVW:	0.40	1.00	**1.50**	2.19	10.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	30.00	**60.00**	73.75	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92540	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92557	XXX	0.60	**RUC Time**

CPT Descriptor COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (92553 AND 92556 COMBINED)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97001	XXX	1.20	**RUC Time**	1,646,248

CPT Descriptor 1 Physical therapy evaluation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90806	XXX	1.86	**RUC Time**	5,502,594

CPT Descriptor 2 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 25.7 %

TIME ESTIMATES (Median)	CPT Code: 92540	Key Reference CPT Code: 92557	Source of Time RUC Time
Median Pre-Service Time	7.00	3.00	
Median Intra-Service Time	60.00	20.00	
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	**77.00**	**28.00**	
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	4.35	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.48
Urgency of medical decision making	3.80	3.35

Technical Skill/Physical Effort (Mean)

Technical skill required	4.18	3.91
Physical effort required	3.44	2.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.83	2.59
Outcome depends on the skill and judgment of physician	4.05	3.85
Estimated risk of malpractice suit with poor outcome	3.21	3.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	2.88
Intra-Service intensity/complexity	4.18	3.59
Post-Service intensity/complexity	3.67	3.35

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.*

e proposed value for this combined code will result in a substantial savings since the total value will be much less than ..e sum of the three individual total values. CMS made a decision to assign professional work to the audiologist's services codes beginning in 2007. Previously the audiology time was captured in PE only. The current professional work for the individual codes packaged into 92540 are based on old Harvard data and is virtually inexplicable because the exact physician activity is not known. Thus, the recommended RVW of 1.5 for 92540 with the elimination of the audiologist time from PE will result in a much lower total 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) This code was previously reported using 92541, 92542, 92544, and 92543.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Audiology How often? Commonly

Specialty Neurology How often? Sometimes

Specialty Otolaryngology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 250000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Used Medicare utilization as a starting point and assumes utilization in non-Medicare patients is slightly less than double.

Specialty Audiology Frequency 112500 Percentage 45.00 %

Specialty Neurology Frequency 25000 Percentage 10.00 %

Specialty Otolaryngology Frequency 112500 Percentage 45.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 140,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number was taken from the 2007 Medicare utilization data in the RUC database

Specialty Audiology Frequency 63000 Percentage 45.00 %

Specialty Neurology Frequency 14000 Percentage 10.00 %

Specialty Otolaryngology Frequency 63000 Percentage 45.00 %

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. 92620 is more appropriate.

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:92570 Tracking Number JJ2 Specialty Society Recommended RVU: **0.60**

Global Period: XXX RUC Recommended RVU: **0.55**

CPT Descriptor: Acoustic immittancetesting, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing.

(Do not report 92570 in conjunction with 92567, 92568, or 92569)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73 year-old female was referred for an audiologic evaluation with the chief complaint of progressive hearing loss and tinnitus in her right ear. No episodes of vertigo or imbalance were reported.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service work includes calling up the tympanometric program on the acoustic immittance unit and entering the patient's demographic information into the system.

Description of Intra-Service Work: Intra-service work for tympanometry begins by seating the patient next to the acoustic immittance unit. The audiologist informs and instructs the patient regarding the tympanometry procedure, apprising the patient regarding what to expect and asking that the patient not swallow or speak once the procedure begins. Otoscopy is then performed to inspect the ear canals and to evaluate the diameter of each canal. From that inspection a probe tip is selected that will permit a hermetic seal. The probe is inserted into the ear canal to a sufficient depth as to permit a hermetic seal. Air is pumped into the ear canal to a level of +200 daPa. The air pressure is then decreased over a range from +200 daPa to -400 daPa with the resulting immittance changes recorded on the instrument's screen. After the first ear is completed, the probe is switched to the opposite ear, and the process is repeated. The audiologist examines the data screen for the configuration of the tympanogram, the static compliance a gradient measurements, and equivalent volume of the ear canal.

The patient is instructed regarding the measurement of acoustic reflex thresholds and informed that she will hear loud sounds of approximately one second each. The probe is re-seated into the ear canal to again obtain a hermetic seal. An insert or supra-aural earphone is seated on the opposite ear to provide acoustic stimulation to elicit the reflexes. The

audiologist then ensures that the pressure in the ear canal corresponds to the maximum tympanic membrane compliance pressure for greatest recording sensitivity. A 500 Hz tone is presented at a level of 100 dB to the ear opposite the probe. The audiologist observes the waveform tracing on the unit screen to determine if there was evidence of a middle ear muscle contraction. If contraction was seen, the intensity of the tone is decreased in 10 dB steps until the reflex contraction is no longer observed. The stimulus intensity is then increased in 5 dB steps until the reflex is recorded once again. The lowest intensity necessary to evoke a middle ear muscle reflex is considered reflex threshold. If a reflex contraction was not observed with the initial stimulation of 100 dB, the intensity of the tone is increased to 105 dB and then 110 dB. This procedure is repeated for the ear contralateral to the probe for 1000 Hz, 2000 Hz, and 4000 Hz. Without adjusting the headset, the equipment is reconfigured to provide the stimulation and record the response through the probe. A similar procedure as described above is employed for the frequencies of 500 Hz, 1000 Hz, and 2000 Hz. After recording acoustic reflexes for contralateral and ipsilateral stimulation for the first ear, the probe is removed, the headset is reversed, the probe is reinserted into the opposite ear, and the procedure is repeated as described above. A total of 14 frequencies (4 right contralateral stimulation, 3 right ipsilateral, 4 left contralateral, and 3 left ipsilateral) are used to evaluate the reflex threshold patterns diagnostically.

For reflex decay determination, the audiologist informs the patient to expect to hear several very loud, possibly uncomfortable, sounds that will each have durations of 10 seconds. After the reflex threshold measurements have been completed, the audiologist re-sets the frequency of stimulation to 500 Hz and through the contralateral earphone presents a tone at a level 10 dB above the reflex threshold (typically between 100 dB and 115 dB HL) for 10 seconds. The acoustic immittance unit records the waveform trace of the strength of muscle contraction for the stimulus duration. The audiologist must examine the trace to determine if an amplitude decrement of 50% or more is present. After the 10 second stimulation, the audiologist must wait at least 30 seconds to permit the ear to recover from the extremely loud stimulus. This procedure is repeated for 1000 Hz with the same headset arrangement. The headset/probe assembly will be reversed to test the opposite ear in the contralateral stimulation paradigm for a total of four recordings.

The tympanogram findings are printed for acoustic reflex thresholds and reflex decay patterns, and the test results are synthesized into other aspects of the audiological evaluation. Test outcomes are recorded in a written report.

Description of Post-Service Work: The audiologist describes the results to the patient and referring physician, if needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Robert C. Fifer, PhD, Kadyn Williams, AuD, Jane Dillon, MD				
Specialty(s):	Audiology, Otolaryngology				
CPT Code:	92570				
Sample Size:	399	**Resp N:**	99	**Response:** 24.8 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	24.50	**150.00**	490.00	2500.00
Survey RVW:	0.25	0.45	**0.60**	0.69	25.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	10.00	**15.00**	18.50	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92570	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**7.00**	**-4.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		
Immediate Post Service-Time:	**3.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**		
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92557	XXX	0.60	**RUC Time**

CPT Descriptor COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (92553 AND 92556 COMBINED)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97530	XXX	0.44	**RUC Time**	5,625,130

CPT Descriptor 1 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97755	XXX	0.62	**RUC Time**	2,618

CPT Descriptor 2 Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32 **% of respondents:** 32.3 %

TIME ESTIMATES (Median)	CPT Code: 92570	Key Reference CPT Code: 92557	Source of Time RUC Time
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	3.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**21.00**	**28.00**
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	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.14
Urgency of medical decision making	3.37	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	3.58	3.25
Physical effort required	2.64	2.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.20
Outcome depends on the skill and judgment of physician	3.55	3.28
Estimated risk of malpractice suit with poor outcome	2.91	2.61

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.50
Intra-Service intensity/complexity	3.44	2.97
Post-Service intensity/complexity	3.06	2.78

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Val. 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) This code was previously reported using 92567, 92568, and 92569.

'ow 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 Audiology How often? Commonly

Specialty Otolaryngology How often? Commonly

Specialty How often?

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. Please explain the rationale for this estimate. Used Medicare utilization as starting point and assumed approximately twice the number of non-Medicare patients with sensory neural hearing loss for differential diagnosis.

Specialty Audiology Frequency 50000 Percentage 50.00 %

Specialty Otolaryngology Frequency 50000 Percentage 50.00 %

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? 50,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number was taken from the 2007 Medicare utilization data the RUC database

Specialty Audiology Frequency 25000 Percentage 50.00 %

Specialty Otolaryngology Frequency 25000 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. 92557

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:92550 Tracking Number JJ3 Specialty Society Recommended RVU: **0.45**

Global Period: XXX RUC Recommended RVU: **0.35**

CPT Descriptor: Tympanometry and reflex threshold measurements

(Do not report 92550 in conjunction with 92567 or 92568)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73 year-old female was referred for an audiologic evaluation with the chief complaint of bilateral tinnitus and a history of occupational noise exposure. No episodes of vertigo or imbalance were reported.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service work includes calling up the tympanometric program on the acoustic immittance unit and entering the patient's demographic information into the system.

Description of Intra-Service Work: Intra-service work for tympanometry begins by seating the patient next to the acoustic immittance unit. The audiologist informs and instructs the patient regarding the tympanometry procedure, apprising the patient regarding what to expect and asking that the patient not swallow or speak once the procedure begins. Otoscopy is then performed to inspect the ear canals and to evaluate the diameter of each canal. From that inspection a probe tip is selected that will permit a hermetic seal. The probe is inserted into the ear canal to a sufficient depth as to permit a hermetic seal. Air is pumped into the ear canal to a level of +200 daPa. The air pressure is then decreased over a range from +200 daPa to -400 daPa with the resulting immittance changes recorded on the instrument's screen. After the first ear is completed, the probe is switched to the opposite ear, and the process is repeated. The audiologist examines the data screen for the configuration of the tympanogram, the static compliance and gradient measurements, and equivalent volume of the ear canal.

The patient is instructed regarding the measurement of acoustic reflex thresholds and informed that she will hear loud sounds of approximately one second each. The probe is re-seated into the ear canal to again obtain a hermetic seal. An insert or supra-aural earphone is seated on the opposite ear to provide acoustic stimulation to elicit the reflexes. The audiologist must then ensure that the pressure in the ear canal corresponds to the maximum tympanic membrane

compliance pressure for greatest recording sensitivity. A 500 Hz tone is presented at a level of 100 dB to the ear opposite the probe. The audiologist observes the waveform tracing on the unit screen to determine if there was evidence of a middle ear muscle contraction. If contraction was seen, the intensity of the tone is decreased in 10 dB steps until the reflex contraction is no longer observed. The stimulus intensity is then increased in 5 dB steps until the reflex recorded once again. The lowest intensity necessary to evoke a middle ear muscle reflex is considered reflex thresho If a reflex contraction was not observed with the initial stimulation of 100 dB, the intensity of the tone is increased to 105 dB and then 110 dB. This procedure is repeated for the ear contralateral to the probe for 1000 Hz, 2000 Hz, and 4000 Hz. Without adjusting the headset, the machine is reconfigured to provide the stimulation and record the response through the probe. A similar procedure as described above is employed for the frequencies of 500 Hz, 1000 Hz, and 2000 Hz. After recording acoustic reflexes for contralateral and ipsilateral stimulation for the first ear, the probe is removed, the headset is reversed, the probe is reinserted into the opposite ear, and the procedure is repeated as described above. A total of 14 frequencies (4 right contralateral stimulation, 3 right ipsilateral, 4 left contralateral, and 3 left ipsilateral) are used to evaluate the reflex threshold patterns diagnostically.

The tympanogram findings are printed and the test results are synthesized into other aspects of the audiological evaluation. Test outcomes are recorded in a written report.

Description of Post-Service Work: The audiologist describes the results to the patient and communicates with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009		
Presenter(s):	Robert C. Fifer,PhD, Kadyn Williams, AuD, Jane Dillon, MD		
Specialty(s):	Audiology, Otolaryngology		
CPT Code:	92550		
Sample Size: 350	**Resp N:** 94	**Response:** 26.8 %	
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**200.00**	500.00	5000.00
Survey RVW:	0.15	0.35	**0.45**	0.50	40.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	6.25	**10.00**	12.00	35.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92550	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**7.00**	**-4.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**3.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92568	XXX	0.29	**RUC Time**

CPT Descriptor ACOUSTIC REFLEX TESTING; THRESHOLD

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97755	XXX	0.62	**RUC Time**	2,618

CPT Descriptor 1 Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97530	XXX	0.44	**RUC Time**	5,625,130

CPT Descriptor 2 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 25.5 %

TIME ESTIMATES (Median)	CPT Code: 92550	Key Reference CPT Code: 92568	Source of Time RUC Time
Median Pre-Service Time	3.00	1.00	
Median Intra-Service Time	10.00	8.00	
Median Immediate Post-service Time	3.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**16.00**	**10.00**	

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	3.48	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.19	2.97
Urgency of medical decision making	3.04	2.79

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.06
Physical effort required	2.33	2.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.19	2.01
Outcome depends on the skill and judgment of physician	3.44	3.24
stimated risk of malpractice suit with poor outcome	2.57	2.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.51	2.39
Intra-Service intensity/complexity	3.12	2.87
Post-Service intensity/complexity	2.81	2.66

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an VPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value commendations 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) This code was previously reported using 92567 and 92568.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Audiology How often? Commonly

Specialty Otolaryngology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Used Medicare utilization data as a starting point and assumed a high utilization for non-Medicare patients with middle-ear disorders.

Specialty Audiology Frequency 1000000 Percentage 50.00 %

Specialty Otolaryngology Frequency 1000000 Percentage 50.00 %

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? 945,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number was taken from 2007 Medicare utilization data in the RUC database.

Specialty Audiology Frequency 472500 Percentage 50.00 %

Specialty Otolaryngology Frequency 472500 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. 92621 is more appropriate.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

CPT Code: 92540

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording.

(Do not report 92540 in conjunction with 92541, 92542, 92544, or 92545)

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 practice expense elements were determined by a consensus panel. The panel drew upon the current practice expense information from the RUC database for codes 92541, 92542, 92544 and 92545.

Please describe in detail 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
1				92540	
	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommedation			Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording.	
2		CMS	Staff		
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME			0.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms				
12	Coordinate pre-surgery services				
13	Schedule space and equipment in facility				
14	Provide pre-service education/obtain consent				
15	Follow-up phone calls & prescriptions				
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	SERVICE PERIOD				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review charts				
21	Greet patient and provide gowning				
22	Obtain vital signs				
23	Provide pre-service education/obtain consent				
24	Prepare room, equipment, supplies				
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV				
27	Sedate/apply anesthesia				
28	**Intra-service**				
29	Assist physician in performing procedure				
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff				
33	Clean Scope				
34	Clean Surgical Instrument Package				
35	Complete diagnostic forms, lab & X-ray requisitions				
36	Review/read X-ray, lab, and pathology reports				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
38	Discharge day management				
39	Other Clinical Activity (please specify) *Collate report information, perform calculations*				
40	**End: Patient leaves office**				
41	POST-SERVICE PERIOD				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions				
44	*Office visits:*				
45	*List Number and Level of Office Visits*				
51	Other				
52	*Total Office Visit Time*			0	0
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				
55	ITEMS INCLUDED				
56	gloves, non-sterile	SB022	pair	1	
57	paper, exam table	SB036	foot	6	
58	towel, non-sterile	SB042	item	2	
59	electrode, ECG (single)	SD053	item	5	
60	applicator, cotton-tipped, non-sterile 6in	SG008	item	2	
61	tape, surgical paper 1in (Micropore)	SG079	inch	12	
62	basin, emesis	SJ010	item	1	
63	electrode conductive paste	SJ021	oz	1	
64	swab-pad, alcohol	SJ053	item	1	
65	paper, recording (per sheet)	SK059	item	12	
66	specula tips, otoscope	SM025	item	1	
67	EQUIPMENT				
68	computer, desktop, w-monitor	ED021		1	
69	chair with headrest, exam, reclining	EF088		1	
70	ENG recording system	EQ025		1	

CPT Code: 92570

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing.

(Do not report 92570 in conjunction with 92567, 92568, or 92569)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The practice expense elements were determined by a consensus panel. The panel drew upon the current practice expense information from the RUC database for codes 92567, 92568, and 92569. All staff time was removed.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

None

CPT Code: 92550

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

Tympanometry and reflex threshold measurements

(Do not report 92550 in conjunction with 92567 or 92568)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The practice expense elements were determined by a consensus panel. The panel drew upon the current practice expense information from the RUC database for codes 92567 and 92568. All staff time was removed.

Please describe in detail 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	D	E	F	G
1				92570		92550	
2	**Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing.**		**Tympanometry and reflex threshold measurements**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**						
5	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
9							
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	**End: When patient enters office/facility for surgery/procedure**						
18							
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure						
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management						
39	Other Clinical Activity (please specify) *Collate report information, perform calculations*						
40	**End: Patient leaves office**						
41							
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions						
44	*Office visits:*						
51	Other						
52	*Total Office Visit Time*			**0**	**0**	**0**	**0**
53	Other Activity (please specify)						
54	**End: with last office visit before end of global period**						
55							
56	ear tip, tympanometry probe	SD046	item	1		1	
57	swab-pad, alcohol	SJ053	item	2		2	
58	paper, recording (per sheet)	SK059	item	3		2	
59	specula tips, otoscope	SM025	item	1		1	
60							
61							
62	tympanometer with printer	EQ244		1		1	

	1	2	3	4	5	6	7
1				92541		92542	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording		Positional nystagmus test, minimum of 4 positions, with recording	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD						
5	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
9	[redacted]						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	**End: When patient enters office/facility for surgery/procedure**						
18	[redacted]						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure						
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management						
39	Other Clinical Activity (please specify) *Collate report information, perform calculations*						
40	**End: Patient leaves office**						
41	[redacted]						
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions						
44	*Office visits:*						
51	Other						
52	*Total Office Visit Time*			0	0	0	0
53	Other Activity (please specify)						
54	**End: with last office visit before end of global period**						
55	[redacted]						
56	electrode, ECG (single)	SD053	item	4		4	
57	cautery, patient ground pad w-cord	SF021	item	1		1	
58	gloves, non-sterile	SB022	item	1		1	
59	specula tips, otoscope	SM025	item	1		1	
60	paper, recording (per sheet)	SK059	item	3		3	
61	electrode conductive paste	SJ021	item	1		1	
62	swab-pad, alcohol	SJ053	item	1		1	
63	applicator, cotton-tipped, non-sterile 6 in	SG008	item	2		2	
64	tape, surgical paper 1in (Micropore)	SG079	item	12		12	
65	basin, emesis	SJ010	item			1	
66	syringe 20 ml	SC053	item				
67	water, distilled	SK087					
68	cotton balls, non-sterile	SG030					
69							
70	[redacted]						
71	chair with headrest, exam, reclining	EF008	min	13		9	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five-Year Review

April 2009

Tendon Transfer

The RUC identified 26480, *Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon*, as potentially misvalued based on the recommendation of the Five Year Review Identification Workgroup. The code was referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that 26480 be surveyed.

The specialty society did not present compelling evidence regarding a change in the work RVU and, instead, provided evidence that the 26480 is correctly valued by its current work RVU of 6.76. The specialty society conducted a survey of 52 hand and orthopaedic surgeons. Survey respondents indicated a median intra-service time of 60 minutes and the specialty societies' expert panel selected pre-service time package number 3, straightforward patient/difficult procedure. The package includes 33 minutes of evaluation time, 15 minutes of scrub time, and the expert panel recommended adding 6 minutes to the 3 minutes of positioning time. The RUC agreed that a total of 9 minutes is required to position the patient's arm and hand throughout the duration of the procedure. The survey respondents indicated 15 minutes of immediate post-service time. No survey respondents indicated that 26480 is performed in the physician office setting and, therefore, one-half of a 99238 discharge day management procedure is appropriate. Survey respondents also indicated that three 99212 office visits and one 99213 office visits are typically performed post-operatively, which the RUC agreed with. The survey median work RVU for 26480 was 8.00, which the specialty and the RUC agreed was too high. Moreover, the current work RVU of 6.76 is lower than the lowest survey response of 6.85. While the survey may indicate that a higher work RVU than the current RVU is warranted, both the RUC and the specialty agreed that there is no compelling evidence beyond the survey to substantiate a change in the work since the code was valued through the Harvard studies. The RUC also looked to the survey key reference service, 25310, *Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon* (work RVU = 7.94), which is a very similar service. The reference service intra-service time is 60 minutes, the same as the median intra-service time for the surveyed code. However, the reference service requires slightly greater pre-service and post-service time. As such, the RUC agreed that the current work RVU of 6.76 for 26480 appropriately ranks the service within the family. **Therefore, the RUC recommends the survey physician times and post-operative office visits, and recommends maintaining the current work RVU of 6.76 for 26480.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
26480		Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	090	6.76 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26480 Tracking Number Specialty Society Recommended RVU: **6.76**

Global Period: 090 RUC Recommended RVU: **6.76**

CPT Descriptor: Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male suffers a loss of the ring finger extensor tendon at the dorsum of the hand. He undergoes a tendon transfer of the extensor indicis proprius to the distal stump of the extensor digitorum communis of the ring finger.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Percent of survey respondents who stated they perform the procedure; In the hospital 37% , In the ASC 63%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 89% , Kept overnight (less than 24 hours) 11% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? 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. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Mark surgical site. Verify that all required instruments and supplies are available. Monitor/assist with pt 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. A tourniquet is applied to the proximal arm. Indicate areas of skin to be prepped. Scrub and gown. The arm and hand are prepped and draped. The arm is elevated and exsanguinated. The pneumatic tourniquet is inflated. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision is made over the dorsal aspect of the fourth metacarpal to expose the residual distal stump of the ring finger extensor digitorum communis. The distal tendon stump is dissected free from any surrounding scar tissue. An incision is made over the distal aspect of the second metacarpal to expose the extensor indicis proprius (EIP). The EIP is clearly identified and transected taking care not to injure the extensor hood. A counter incision is made at the distal edge of the extensor retinaculum and the EIP is identified and brought into the proximal wound. The EIP is freed of any connections to adjacent extensor tendons. A subcutaneous tunnel is created from the proximal wound to the distal stump of the ring finger extensor tendon. The EIP is gently passed in to the tunnel from proximal to distal. The EIP is then sutured to the distal stump of the ring finger extensor tendon taking care

to apply the appropriate tension. The tension on the tendon transfer is adjusted as needed. The wound is irrigated and then closed in layers.

Description of Post-Service Work:
Facility: Apply bulky dressing, reinforced with a splint. Discuss postoperative care with recovery room staff. Disc. surgery outcome with patient/family. Write brief operative note and medication orders in patient's chart. Monitor patient stabilization in the recovery room and circulation, sensation and motor function status of the operated extremity. Dictate operative report. Consider relevant data, options, and risks and make the decision for discharge. Discuss aftercare treatment with the patient/family including home restrictions (ie, activity, bathing). Reconcile medications and write order for pain medication. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office: The patient is examined in the office the next day to remove dressings, assess circulation, sensation and motor function status, and redress wound. An order is written for the fabrication of a dynamic finger extension splint. At the end of the second postoperative week, the patient undergoes suture removal. At this visit and all other follow-up visits through the 90-day global period, the splint and range of motion are assessed; the occupational therapy prescription is adjusted as needed; and all necessary medical records and insurance forms are completed, included progress notes for the PCP.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009
Presenter(s):	Daniel Nagle, MD, FACS
Specialty(s):	hand surgery, orthopaedic surgery
CPT Code:	26480

Sample Size:	200	**Resp N:**	52	**Response:** 26.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**6.00**	11.00	50.00
Survey RVW:	6.85	7.99	**8.00**	9.00	11.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	45.00	**60.00**	60.00	100.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**71.00**	99211x **0.00** 12x **3.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	26480	**Recommended Physician Work RVU: 6.76**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**9.00**	**3.00**	**6.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**71.00**	99211x **0.00** 12x **3.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
25310	090	7.94	**RUC Time**

CPT Descriptor Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 44 **% of respondents:** 84.6 %

TIME ESTIMATES (Median)	CPT Code: 26480	Key Reference CPT Code: 25310	Source of Time RUC Time
Median Pre-Service Time	57.00	65.00	
Median Intra-Service Time	60.00	60.00	
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	19.00	
Median Office Visit Time	71.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**222.00**	**235.00**	
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	3.21	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.55	2.62
Urgency of medical decision making	2.93	2.89

Technical Skill/Physical Effort (Mean)

Technical skill required	3.71	3.62
Physical effort required	2.62	2.72

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	3.10
Outcome depends on the skill and judgment of physician	3.90	3.79
Estimated risk of malpractice suit with poor outcome	2.93	2.74

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.26	3.29
Intra-Service intensity/complexity	3.45	3.37
Post-Service intensity/complexity	3.05	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.*

We are pleased to present survey data for CPT Code 26480 which was screened by the RUC 5YR ID Workgroup and CMS as one of the *fastest* growing procedures (>10%) in the Medicare fee schedule without regard to total number of procedures performed (ie, less than 400). The table below presents the RUC database Medicare utilization that resulted in the requirement / recommendation that we survey this code:

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Freq	1,199	1,380	1,237	1,275	1,433	1,653	1,821	2,149	2,542	2,752	3,002
Chg		181	-143	38	158	220	168	328	393	210	250
%Chg		15%	-10%	3%	12%	15%	10%	18%	18%	8%	9%

Our consensus panel does not believe there is compelling evidence regarding a change in patient or technology to recommend an increase for code 26480. Without compelling evidence, we understand the current review is limited to evaluating whether the current RVW is correct. We agree with the survey data that indicate the typical patient is discharged from a facility on the day of the procedure (ie, same-day discharge). We also believe the intra-op time and post-op visits are an accurate representation of what is currently necessary for this procedure.

In comparison to the key reference code 25310 *Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon*, the survey code 26480 is almost identical - with the exception of incision location on the hand. Pre- and post-service work would be similar for both codes. The value for 26480 (RVW=6.76) and the recommended time and visit data result in an IWPUT of 0.041 which is less than the intensity of 99213. We believe the current survey data supports the current RVW of 6.76 for 26480.

SERVICES REPORTED WITH MULTIPLE 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) 26480

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty hand surgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty plastic surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 9000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Our consensus panel estimates the ratio is 3:1 for non-Medicare to Medicare patients, based on personal experience in the past year.

Specialty hand surgery Frequency 5600 Percentage 62.22 %

Specialty orthopaedic surgery Frequency 2500 Percentage 27.77 %

Specialty plastic surgery Frequency 750 Percentage 8.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2007 Medicare data

Specialty hand surgery Frequency 1880 Percentage 62.66 %

Specialty orthopaedic surgery Frequency 830 Percentage 27.66 %

Specialty plastic surgery Frequency 247 Percentage 8.23 %

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. Use current code 26480.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

			Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings					Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings									Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in Intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1		60	0	L037D			4	0		0			-1	1		Yes	9
28120	50	50	1	0	3	2	0	67	-17	L037D	1	0	3.5	0	0	-17	0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0	51	-6	L037D	1	0	5	0	0	-6	0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0	60	30	L037D	1	0	4	0	0	0	0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0	120	-20	L037D	1	0	0	5	0	0	0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0	81	39	L037D	1	0	2.5	0	0	0	0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0	156	-6	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0	182	-2	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0	67.5	2.5	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0	90	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0	60	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
69100	12	8						10	2	L037D						1						No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Moderate Sedation Practice Expense Inputs

In 2005, CPT began identifying services in which moderate sedation is inherent and listed them in a separate addendum. The CMS reviewed its direct practice expense inputs database in 2008 and found 12 CPT codes that had moderate sedation practice expense inputs but were not listed in CPT's moderate sedation addendum. All 12 codes had been reviewed for practice expense direct inputs by the RUC prior to CPT 2005. CMS removed the moderate sedation inputs of all 12 codes for its 2009 physician fee schedule calculations and asked specialty societies to bring any of the codes forward to the RUC to reestablish the inputs. In February 2009, specialty societies contended that moderate sedation was inherent to two of these codes. The RUC discussed and agreed that moderate sedation was inherent in codes 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic*, and 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar.* **The RUC recommends that the moderate sedation practice expense inputs be added back to codes 22520 and 22521. In addition, the RUC recommends codes 22520 and 22521 be placed on CPT's Appendix G, summary of CPT codes that include moderate (conscious) sedation.**

1672

CPT Code	CPT Descriptor	Global Period	Recommendation
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	010	Practice Expense Only
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	010	Practice Expense Only

	A	B	C	D	E	F	G	H
1	**AMA/Specialty Society RVS Update Committee Recommendation**							
2			**22520**			**22521**		
3		**CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE**	**Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic**			**Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar**		
4	**LOCATION**		**In Office**		**Out Office**	**In Office**		**Out Office**
5	**GLOBAL PERIOD**		**010**		**010**	**010**		**010**
6	**STAFF TYPE (Blend = RN/LPN/MA)**		**Blend**	**RN**	**Blend**	**Blend**	**RN**	**Blend**
7	**TOTAL CLINICAL LABOR TIME**		**143.0**	**97.0**	**72.0**	**140.0**	**92.0**	**72.0**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**		**21.0**	**0.0**	**30.0**	**21.0**	**0.0**	**30.0**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		**83.0**	**97.0**	**6.0**	**80.0**	**92.0**	**6.0**
10	**TOTAL POST-SERV CLINICAL LABOR TIME**		**39.0**	**0.0**	**36.0**	**39.0**	**0.0**	**36.0**
11	**PRE-SERVICE**							
12	**Start: Following visit when decision for surgery or procedure made**							
13	Complete pre-service diagnostic & referral forms		5		5	5		5
14	Coordinate pre-surgery services		3		10	3		10
15	Schedule space and equipment in facility		3		5	3		5
16	Office visit before surgery/procedure: Review test and exam results							
17	Provide pre-service education/obtain consent		7		7	7		7
18	Follow-up phone calls & prescriptions		3		3	3		3
19	Other Clinical Activity (please specify)							
20	**End:When patient enters office/facility for surgery/procedure**							
21	**SERVICE PERIOD**							
22	**Start: When patient enters office/facility for surgery/procedure**							
23	**Pre-service services**							
24	Review charts		2			2		
25	Greet patient and provide gowning		3			3		
26	Obtain vital signs		5			5		
27	Provide pre-service education/obtain consent							
28	Prepare room, equipment,supplies		5			5		
29	Prepare and position patient/ monitor patient/ set up IV		3			3		
30	Sedate/apply anesthesia			2			2	
31	**Intra-service**							
32	Assist physician in performing procedure		53	80		50	75	
33	**Post-Service**							
34	Monitor pt. following service/check tubes, monitors, drains			15			15	
35	Clean room/equipment by physician staff		3			3		
36	Complete diagnostic forms, lab & X-ray requisitions		2			2		
37	Review/read X-ray, lab, and pathology reports		2			2		
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		5			5		
39	Coordination of Care							
40	Discharge day management 99238 –12 minutes 99239 –15 minutes				6			6
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		3			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							
47	*List Number and Level of Office Visits*							
48	99211 16 minutes	16						
49	99212 27 minutes	27						
50	99213 36 minutes	36	36		36	36		36
51	99214 53 minutes	53						
52	99215 63 minutes	63						
53	Other							
54								
55	*Total Office Visit Time*		36		36	36		36
56	Other Activity (please specify)							
57	**End: with last office visit before end of global period**							

	A	B	C	D	E	F	G	H
2			22520			22521		
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic			Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar		
4	LOCATION		In Office		Out Office	In Office		Out Office
58	**MEDICAL SUPPLIES**							
59	Basic Injection Package							
60	EM Code Supply Package							
61	Minimum Supply Package		2		1	2		1
62	Post-Operative Incision Care Kit							
63	Conscious sedation Package		1			1		
64	Chux	11102						
65	Surgical mask with face shield	11301	3			3		
66	Gown, impervious staff	11304						
67	Surgical cap	11305	3			3		
68	Surgical mask	11306						
69	Mayo stand cover	11517	1			1		
70	Sterile drape	14001						
71	Sterile Drape Femoral (extremity)	14002						
72	Gloves (sterile)	14005	2			2		
73	Sterile surgical gown	14008	2			2		
74	Sterile drape pack, chest, abdomen	14011	1			1		
75	Disposable scapel, #11,15, or 20 blade	11504	1			1		
76	Skin marking pen	11524	1			1		
77	Cotton tip applicator	31103						
78	Sterile gauze-(10 pack)	31505	1			1		
79	Kling roller bandage 2x 131	31509						
80	Bandaid	31502						
81	Steri strips	31513	6			6		
82	Tape	31514						
83	suture removal kit	31703						
84	Vicryl suture 3-0,4-0,5-0	31704						
85	Vicryl suture 3-0	31711						
86	Grounding pad	31713						
87	Xylocaine 1% 20 ml	51503	20			20		
88	Bupivicaine 0.25%	51510						
89	Betadine	52301						
90	Bacitracin unit dose pack, .9g							
91	Hydrogen peroxide	52303						
92	Betadine swab (3 pack)	52305						
93	18 guage fliter needle	71014						
94	IV extension tubing	91109						
95	Needle 18-24 gauge	91402	1			1		
96	Needle 25-26 gauge	91403	1			1		
97	Spinal Needle	92016	1			1		
98	Syringe 5cc	91411						
99	Syringe 10cc	91407						
100	Biopsy needle	92012						
101	Electosurgical applicator (bovie)	93109						
102	Irrigation fluid, 1000cc	93401						
103	Suction tubing 6 ft with Yankauer tip	93606						
104	Suction canister, disposable	93604						
105	Bulb syringe	93607						
106	electrocaudry tip							
107	Skin prep one step - Dura Prep	$7.50	1			1		
108	Methylmethacrylate Cement	$103	1			1		
109	Barium	$70	1			1		
110	Vertebroplasty Kit	$1,295	1.5			1.5		
111	Racz Catheter	$65						
112	RK needle	$18						
113	supplies for 72275							
114	Interstim Unimary Control Simulation Kit							
115	hair clipper	$5						
116	Spinal Cord stimulation Kit							
117	Sterile Fluroscopy drape	$5	1			1		
118	**Equipment**							
119	Exam table	E11001						
120	Power exam table	E11003	1		1	1		1
121	Stretcher	E11002	60			60		
122	Suction machine	E30001						
123	Electrocaudry	E30005						
124	Exam lamp	E30006						
125	Percutaneous Test Nerve stimulator Medtronic							
126	X-Ray view box	E51001	1			1		
127	Radiographic/fluoroscopy room	E51005	90			90		
128	Minor surgical pack	E72006	1			1		
129	Conscious sedation Equipment		1			1		
130	Stereotactic frame or tongs							

facility PE RVUs and § 414.22(b)(5)(i)(B) discusses nonfacility PE RVUs. Language in each of these sections incorrectly implies that the facility PE RVU is lower than or equal to the nonfacility PE RVUs. However, there are some instances where the facility PE RVUs may actually be greater than the nonfacility PE RVUs. In order to address this inaccuracy, we proposed to revise § 414.22(b)(5)(i)(A) and (B) to remove this language.

We received no comments on our proposed technical change and have revised the regulations at § 414.22(b)(5)(i)(A) and (B) as proposed.

e. Other PE Direct Input Issues

(i) *Removal of Conscious Sedation (CS) PE Inputs for Services in Which CS is not Inherent—Technical Correction*

In reviewing the PE database, we noted that the conscious sedation (CS) PE inputs for 12 CPT codes in which CS is not inherent had not been removed after CPT 2005 began identifying these codes in a separate Addendum. The CS inputs for CPT codes 19300, 22520, 22521, 31717, 62263, 62264, 62268, 62269, 63610, 64585, 64590, and 64595 had been added by the AMA RUC's PEAC prior to CY 2005. At that time, the AMA RUC recommended deletion of the CS PE inputs for all procedures that were not identified in the CPT 2005 manual Addendum which lists the services in which CS is inherent; and thus include the associated direct PE inputs. Due to a technical error, these inputs were not removed for CY 2005. We have removed the CS PE inputs for the 12 CPT codes noted above. We ask that the AMA RUC permit specialty societies to bring any CPT codes forward to either the February or April 2009 AMA RUC meetings should any other discrepancies between the CPT Addendum and the PE database be identified.

(ii) Jejunostomy Tube Price

A comment received on the CY 2009 PFS proposed rule stated that we had mistakenly entered the price for a set of 2, rather than just 1, jejunostomy tube in each of the following CPT codes 49441, 49446, 49451, and 49452. So that the price of this PE supply can be properly valued as part of the PE RVUs for each of the four services in which it is found, we have changed the price of this supply from $198 to $97.50 in CPT codes 49441, 49446, 49451, and 49452. In addition, because it's correct price is less than $150, this item was erroneously placed on the list for re-pricing of higher-cost supplies on Table 29 in the proposed rule; and, as a result of this price correction, it has been removed from the list of supply items in need of repricing.

(iii) Supply Code SH079, Collagen, Dermal Implant (2.5ml uou) (Contigen)

We received comments from a specialty society representing urologists noting that the dermal collagen implant, priced at $317, was an inappropriate supply input for CPT 52330. The specialty society asked that we remove this supply from this service. We agree that inclusion of the dermal collagen implant as a supply input for CPT code 52330 is not appropriate. The PE RVUs for CPT 52330 reflect the removal of this supply item.

(iv) Contractor Pricing of CPT 77371 for Stereotactic Radiosurgery (SRS) Treatment Delivery

CPT code 77371, *Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based,* (more commonly known as Gamma Knife) was a new CPT code for CY 2007. At that time, we accepted nearly all of the AMA RUC PE recommendations for this procedure (we did not accept the Cobalt 60 radiation source as a direct PE input) during CY 2007 rulemaking, and these recommendations are reflected in the PE RVUs for CPT 77371. The PE inputs for CPT 77371 had been proposed by the sitting AMA RUC specialty society representing therapeutic radiation oncology physicians. The AMA RUC discussed and amended the specialty's proposal for direct PE inputs (particularly the amount of clinical labor time) prior to agreeing on the final AMA RUC recommendation that was forwarded to CMS for CY 2007. Due to the equipment expense (nearly $4 million) along with the many Nuclear Regulatory Commission (NRC) requirements for construction of the facility required to furnish these procedures, all but one of these facilities is connected with a hospital setting, leaving a single free-standing nonfacility provider.

Comment: We received 3 comments stating that the PE RVUs listed in Addendum B for CPT 77371 are exceptionally inadequate. All commenters, including the single freestanding nonfacility based provider, noted the difference in payments between those made under OPPS and the PFS for CPT 77371. For CY 2009, the commenters noted that the proposed OPPS payment is $7,608 and the PFS payment under the proposed rule would be $1,260. A freestanding nonfacility provider noted that it had worked with the Medicare contractor but was unsuccessful in securing a higher payment because the contractor could not deviate from the established PE RVUs. Two commenters also stated that they believe the direct PE inputs are incorrect since the cost data they had gathered from other facility providers of this stereotactic radiosurgery (SRS) service included extra clinical labor time due to Nuclear Regulatory Commission (NRC) requirements for both the physicist and the registered nurse. In addition, they disagreed with our decision to treat the Cobalt 60 radiation source (recommended by the AMA RUC as a 1-month renewable equipment item) as an indirect PE cost in the CY 2007 PFS final rule with comment period. The commenters have asked us to contractor-price CPT 77371 for CY 2009 if a payment correction cannot be made in the final rule.

Response: We will ask the AMA RUC to review the direct PE inputs for this code in light of these comments. In the interim, we believe the commenters have raised sufficient questions regarding the propriety of the direct PE inputs and PE RVUs established for this new code in 2007 to warrant contractor-pricing for CPT 77371 for CY 2009.

f. Supply and Equipment Items Needing Specialty Input

We have identified some supply and equipment items from the CY 2008 final rule with comment period for which we were unable to verify the pricing information (see Table 2: Items Needing Specialty Input for Pricing and Table 3: Equipment Items Needing Specialty Input for Pricing). For the items listed in Tables 2 and 3, we are requesting that commenters provide pricing information. In addition, we are requesting acceptable documentation, as described in the footnote to each table, to support the recommended prices. For supplies or equipment that previously appeared on these lists, we may propose to delete these items unless we receive adequate information to support current pricing by the conclusion of the comment period for this final rule.

In Tables 4 and 5, we have listed specific supplies and equipment items related to new CY 2009 CPT codes that are discussed in section V. of this final rule with comment period. We have added these items to the PE database along with the associated prices (on an interim basis). We plan to propose finalized pricing information in the CY 2010 PFS proposed rule. Item prices identified in these tables are also reflected in the PE RVUs in Addendum B. In addition, we have asked commenters to submit specific information in response to the

ACR™
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SOCIETY OF INTERVENTIONAL RADIOLOGY
Enhanced care through advanced technology™

January 6, 2009

William Rich, MD, Chair, RUC
Bill Moran, MD, Chair, PERC Subcommittee
Physician Payment Policy and Systems
American Medical Association
515 N. State Street
Chicago, IL 60610

RE: Conscious Sedation Direct Practice Expense Inputs for Codes 22520 and 22521

Dear Drs. Rich & Moran:

The American College of Radiology (ACR) and Society of Interventional Radiology (SIR), represent the dominant specialties performing vertebroplasty procedures (reported using codes 22520/ 22521) as per the 2006 Medicare claims data in the RUC Database. We find that moderate (conscious) sedation is inherent to the performance of vertebroplasty. The ACR and SIR support the continued inclusion of conscious sedation direct practice expense for the non-facility setting for these codes. Additionally, we respectfully, request that the RUC advise the CPT Editorial Panel to add codes 22520 and 22521 to Addendum G of the CPT manual *(Summary of CPT Codes that include Moderate (Conscious) Sedation)*.

In support of this request, please find attached supporting literature with articles that specifically include mention of moderate (conscious) sedation in the description of the technique for vertebroplasty.

Your consideration of this request is greatly appreciated.

Sincerely,

Geraldine McGinty, MD
ACR RUC Advisor

Sean M Tutton, MD
Sean Tutton, MD
SIR RUC Advisor

CC: Pam West, CMS
Todd Klemp, AMA
Bibb Allen, MD, ACR
Robert Vogelzang, MD, SIR
Gerald Niedzwiecki, MD, SIR
Dan Picus, MD, ACR
Scott Trerotola, MD, ACR
Diane Hayek, ACR
Angela Kim, ACR
Deborah Ramsburg, SIR
Dawn R. Hopkins, SIR

Percutaneous Vertebroplasty in Patients With Intractable Pain From Osteoporotic or Metastatic Fractures: A Prospective Study Using Quality-of-Life Assessment

Gordon Cheung, MD, FRCPC; Edward Chow, MBBS, MSc, FRCPC; Lori Holden, BSc, MRTT; Marjan Vidmar, MD, MSc; Cyril Danjoux, MD, FRCPC; Albert JM Yee, MD, FRCSC; Ruth Connolly, BSc, MRTT; Joel Finkelstein, MD, FRCSC

Abstract

Purpose: Percutaneous vertebroplasty (PVP) is a minimally invasive outpatient procedure whereby vertebral compression fractures are stabilized by the injection of bone cement, or polymethyl methacrylate (PMMA). Rapid partial or complete pain relief can usually be achieved through this procedure. We prospectively evaluate the efficacy of PVP in the relief of pain and improvement in quality of life of patients with intractable pain from osteoporotic and metastatic fractures.

Materials and Methods: Patients with intractable pain from vertebral metastases (many resistant to palliative radiation therapy) and patients with intractable painful osteoporotic fractures were treated with parapedicular or transpedicular injection of PMMA. Plane X-rays, computed tomography (CT) scan, and magnetic resonance imaging (MRI) scan were performed on all patients. With a reflex hammer, percussion pain was correlated to the imaging abnormalities. The preplanning CT scan was used to calculate the exact entry point and angle of the bone-biopsy needle. All patients were assessed before and after the procedure for quality of life and amount of pain. The following measures were used: 1) the Edmonton Symptom Assessment System (ESAS), for global pain, nausea, tiredness, depression, anxiety, drowsiness, appetite, sense of well-being, and shortness of breath; 2) a site-specific pain score (SSPS); 3) the amount of analgesic intake in morphine equivalents in the last 24 hours; and 4) the Townsend Functional Assessment Scale (TFAS), ascertaining mobility. A postprocedural CT scan was performed the same day on all patients. Follow-up assessment consisted of a phone call at Days 1, 2, and 4 and Weeks 1, 2, 4, 8, and 12. Patients with recurrent back pain or complications were followed in the bone metastases clinic.

Results: Thirty patients (19 women, 11 men) were evaluated. Their median age was 68 years (range 31 to 87 years). Thirty procedures (n = 30) at 45 vertebral levels were performed; 13 were for pathologic fractures, and 17 were for osteoporotic fractures. SSPS showed a decrease of 2 or more levels in 88.5% of patients at 12-week follow-up. The mean SSPS with movement was 8.7 preprocedure and 1.8 postprocedure ($P < 0.0001$). Also, there was significant improvement in all 9 ESAS domains ($P < 0.0004$). The ingestion of analgesics in morphine equivalents showed a trend toward reduction post-PVP ($P < 0.0599$). When the patients with pathologic fractures were separated out, the reduction in ingestion of analgesics was significant ($P < 0.0008$). The TFAS demonstrated significant improvement in patient mobility and function. Extravertebral extravasation of cement was noted in 55.6% of the levels. We used a general linear mixed-model repeated-measures analysis of variance to analyze the data.

Conclusions: PVP in osteoporotic and metastatic fractures significantly improved many patients' global quality-of-life scores and function by markedly decreasing their back pain and reducing their intake of pain medications. The procedure is safe, with no serious complications noted in our study.

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Abrégé

Objectif : La vertébroplastie percutanée (VPP) est une intervention effractive minimale pratiquée sur les patients externes, par laquelle les fractures de tassement vertébral sont stabilisées par l'injection de ciment d'os, ou polyméthacrylate de méthyle (PMMA). Un soulagement rapide partiel ou complet de la douleur s'obtient habituellement grâce à cette intervention. Nous avons évalué prospectivement l'efficacité de la VPP à soulager la douleur et à améliorer la qualité de vie des patients souffrant de douleur irréductible à cause de fractures ostéoporotiques et métastatiques.

Matériel et méthodes : Des patients souffrant de douleur irréductible à cause de métastases vertébrales (dont beaucoup résistent à la radiothérapie palliative) et des patients souffrant de fractures ostéoporotiques douloureuses rebelles ont été traités par injection de PMMA parapédiculaire ou transpédiculaire. Des radiographies planes, des tomodensitogrammes et des imageries par résonance magnétique (IRM) ont été exécutés pour tous les patients. À l'aide d'un marteau à réflexe, la douleur de la percussion était corrélée aux anomalies de l'imagerie. Le point d'entrée exact et l'angle de l'aiguille de la biopsie osseuse ont été calculés à l'aide du tomodensitogramme préparatoire. La qualité de vie et l'intensité de douleur de tous les patients ont été évaluées avant et après l'intervention. Les mesures suivantes ont été utilisées : 1) le système d'évaluation des symptômes d'Edmonton (ESAS), pour la douleur générale, la nausée, la fatigue, la dépression, l'anxiété, la somnolence, l'appétit, le sentiment de bien-être et l'essoufflement; 2) une échelle de douleur spécifique au site (SSPS); 3) la quantité d'analgésique prise en équivalents de morphine dans les 24 dernières heures; et 4) l'échelle d'évaluation fonctionnelle de Townsend (TFAS), estimant la mobilité. Un tomodensitogramme post-intervention a été effectué le même jour pour tous les patients. L'évaluation de suivi consistait dans un appel téléphonique aux 1er, 2e et 4e jours, et aux 1re, 2e, 4e, 8e et 12e semaines. Les patients ayant des maux de dos récurrents ou des complications ont été suivis à la clinique des métastases osseuses.

Résultats : Trente patients (19 femmes, 11 hommes) ont été évalués. L'âge moyen était de 68 ans (de 31 à 87 ans). Trente interventions (n = 30) à 45 niveaux vertébraux ont été exécutées. Treize interventions étaient pour des fractures pathologiques, et 17 traitaient des fractures ostéoporotiques. La SSPS a indiqué une diminution de 2 niveaux ou plus chez 88,5 % des patients à la 12e semaine de suivi. La moyenne de la SSPS avec mouvement était de 8,7 pré-intervention, et de 1,8 post-intervention (P < 0,0001). De même, il y avait une amélioration significative dans tous les 9 domaines du ESAS (P < 0,0004). La prise d'analgésiques en équivalents de morphine indiquait une tendance à la réduction après la VPP (P < 0,0599). Lorsque les patients ayant des fractures pathologiques ont été séparés, la réduction de la prise d'analgésiques était significative (P < 0,0008). La TFAS démontrait une amélioration significative de la mobilité et du fonctionnement des patients. L'extravasation extravertébrale du ciment a été notée dans 55,6 % des niveaux. Nous avons utilisé une analyse de la variance à mesures répétées selon un modèle mixte général linéaire pour analyser les données.

Conclusions : La VPP pour les fractures ostéoporotiques et métastatiques a amélioré significativement les scores généraux de qualité de vie et le fonctionnement de nombreux patients, en diminuant considérablement leurs maux de dos et en réduisant leur prise d'analgésiques. L'intervention est sûre, sans complications sérieuses notées dans notre étude.

Percutaneous vertebroplasty (PVP) was first pioneered in France by Galibert et al in 1987 for treating hemangiomas involving the spine.[1] PVP has become increasingly popular for the treatment of intractable pain due to vertebral collapse from various diagnoses. Reported not only for benign conditions such as vertebral hemangiomas and osteoporotic vertebral fractures,[2,3] the technique has been increasingly used for pathologic fractures resulting from primary or metastatic malignancies or metabolic bone diseases.[4–11]

Few large clinical series exist, and despite the increasing use of PVP, there are to date no controlled prospective studies on its safety and efficacy with long-term follow-up. Moreover, there are few prospective studies that evaluate quality of life and function measures according to validated generic and disease-specific measures.[12–16] This study prospectively evaluates the efficacy of PVP in the relief of pain and improvement in quality of life of patients with intractable pain from osteoporotic and metastatic fractures.

Materials and Methods

Patient Demographics

We studied 30 PVP procedures performed on 30 consecutive eligible patients for 45 treated levels; the patients had intractable pain from osteoporotic or metastatic fractures. We define a procedure as a case performed at a single sitting, whether 1, 2, or 3 vertebroplasties were performed. A single operator performed the procedure in a single tertiary care centre on patients referred over a 2-year period between July 2000 and September 2002. Patients were referred for the evaluation of acute vertebral body collapse diagnosed radiographically. Inclusion criteria for PVP included fractures occurring without trauma or with minor trauma (such as fall from standing height). Patients over age 18 years with intractable thoracic or lumbar pain secondary to a vertebral fracture were eligible. Pain was present for a minimum of 4 weeks and refractory to conservative therapy (that is, rest, activity modification, physical therapy, and analgesics) in the osteoporotic group and to conservative or palliative radiation therapy in the metastatic group. Other criteria included clinical examination for percussion tenderness with a reflex hammer, correlating to an osteoporotic or metastatic fracture on imaging with computed tomography (CT) and magnetic resonance imaging (MRI). We excluded patients with coagulopathy, retropulsion of bone, or epidural tumour causing significant thecal sac compression or neural foraminal narrowing. We also excluded patients presenting with neurologic deficits related to the spine. Significant vertebral body collapse to less than one-third of height was a relative contraindication.

A multidisciplinary team consisting of an orthopedist, a radiation oncologist, and a neuroradiologist assessed the patients. Routine anteroposterior and lateral plain radiographs, CT scan (LightSpeed QX/i CT scanner, GE Healthcare, Milwaukee, WI), and MRI (Signa LX Twin Speed MRI scanner, GE Healthcare)

Table 1 Age and sex of patients by fracture type

Fracture Type	Sex	*n*	Age (years) Median	Range
Cancer		13	66	31–87
	Women	8	64	31–77
	Men	5	77	60–87
Osteoporosis		17	68	49–87
	Women	11	68	60–87
	Men	6	64	49–81

imaging were performed on all patients. The decision to treat each patient with PVP was reached by consensus. The study cohort consisted of 30 patients, on whom vertebroplasties were performed at 45 vertebral levels. Informed consent was obtained from all patients for the PVP procedure.

Imaging review

Preprocedural MRI scans were performed on all patients to assess for those patients with significant vertebral plana, neural foraminal compression, or significant thecal sac compromise from bony retropulsion or epidural tumour. To facilitate a safe procedure, the entry point and angle of the bone-biopsy needle were calculated with a planning CT scan with the patient in prone position.

Procedural Technique

A single operator performed each PVP. Thirty minutes before the procedure, 1 g of intravenous cefazolin (Ancef) and 10 mg of dexamethasone (Decadron) were administered. Conscious sedation for the procedure included 50 μg of intravenous fentanyl and 5 mg of midazolam (Versed). Patients were then placed prone on an angiogram table (Integris V3000, Philips, The Netherlands). All patients were treated with fluoroscopic guidance. In general, a parapedicular approach was used for thoracic fractures and a transpedicular approach was used in lumbar fractures. The entry point on the patient's skin and the angle of the needle were extrapolated from the preplanning CT scan. Liberal local anesthesia with lidocaine was given. An Osteo-Site (Cook, Bloomington, IN) bone-biopsy needle (11- or 13-Gauge) was directed into the anterior one-third of the vertebral body, guided fluoroscopically and by gentle taps with an orthopedic hammer. Chilled Codman cranioplastic polymer powder (Johnson & Johnson, Raynham, MA) was mixed with 1.5 vials (9 g) of sterile barium sulfate to increase its opacity. The cement was injected through the bone-biopsy needle under close fluoroscopic guidance. The injection was terminated when the cement reached the posterior one-third of the vertebral body or when paravertebral or epidural venous filling was seen. A total of 3 to 6 mL was injected into the vertebral body. A postprocedural CT scan of the treated levels was performed the same day on all patients to evaluate vertebral body fill and potential cement extravasation. Patients were discharged the same day.

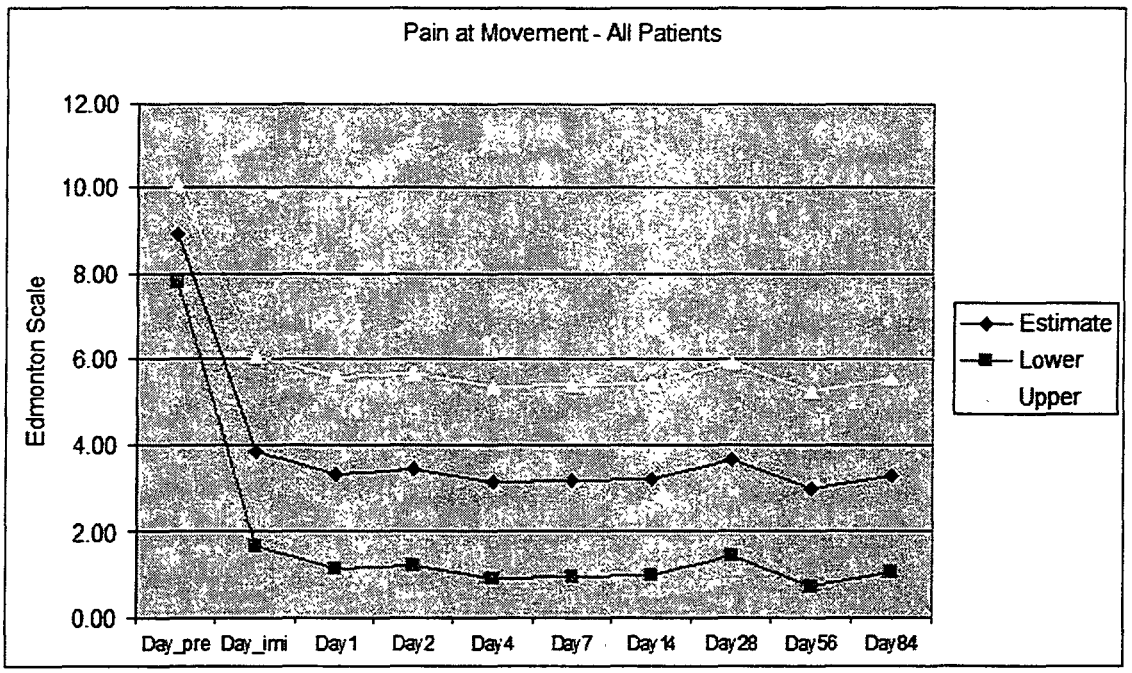
A bone biopsy was not felt to be necessary in any of the patients because the differentiation of osteoporotic fracture and pathologic fracture was never in question, according to the CT and MRI findings.

Outcome Measures

We assessed quality of life for all patients before and after the procedure, using 1) the Edmonton Symptom Assessment System (ESAS),[17] 2) the Townsend Functional Assessment Scale (TFAS),[18] 3) morphine equivalents, and 4) a site-specific pain score (SSPS). Patients were evaluated postprocedure by telephone calls on Days 1, 2, and 4 and at Weeks 1, 2, 4, 8, and 12. The ESAS was designed to assess the multidimensional nature of quality of life specific to palliative care and has been demonstrated to be valid and reliable in patients with terminal cancer.[17,19] The ESAS is a 9-item, patient-rated, symptom verbal rating scale with domains in global pain, nausea, tiredness, depression, anxiety, drowsiness, appetite, sense of well-being, and shortness of breath. Each domain is scored from 0 to 10, with higher scores representing increased disability. The TFAS is a physician-determined categorical assessment of the patient's physical disability. Patients were classified into 1 of 4 categories: A = normal pain-free function, B = normal function with pain, C = significantly limited function requiring some type of prosthesis (for example, for lower extremity, a walker, a cane, or crutches for ambulation), and D = nonfunctional (for example, wheelchair-bound or bedridden). Before and after the procedure, the patient's amount of oral analgesic and narcotic intake in the preceding 24 hours was converted to morphine equivalents according to standardized equivalence tables. The patient's back pain at the site of the fracture was evaluated with the SSPS, (range 0 to 10, with 0 = pain-free and 10 = worst pain possible), both at rest and with movement. This was a subjective verbal evaluation determined from the patient's response. Site-specific pain is defined as a specific focal area of back pain that can easily be localized by the patient and by the radiologist with percussion by a reflex hammer; this site correlates closely with a vertebral fracture.

Of the 30 patients, 3 had subsequent successful pain-relieving vertebroplasty procedures, but we used only the data from the first vertebroplasty procedure in our analysis to avoid skewing the results (2 were for new adjacent fractures, and one was for a nonadjacent metastasis). Any missing values for quality of life, morphine equivalents, and SSPS were replaced with a median value calculated by using the postoperative data to increase the precision of the results. Three patients did not complete the study. Two died (one by Week 2 and one by Week 4), and one

Figure 1 Site-specific pain score (SSPS), pain with movement. Estimates are averages that were produced with the repeated measure analysis, general linear mixed model. The lower and upper values indicate the 95% confidence interval.



withdrew during Week 4. For these 3 patients, the data collected up to Day 14 were included in the analysis.

Statistical analysis

To evaluate the effect of PVP on patient-derived ESAS quality-of-life domains, morphine-equivalent analgesic requirements, and SSPS, we compared preprocedural and the postprocedural values, using used a general linear mixed-model repeated measures analysis of variance. For multiple comparisons, statistical significance was assumed to be a P value of less than 0.01. Any missing values for quality-of-life measures, morphine equivalents, and SSPS were replaced with the median value, which we calculated from postprocedural data only.

Results

PVP was performed on 30 patients for a total of 30 procedures at 45 treated vertebral levels. The patients included 19 women and 11 men with a mean age of 67.2 years (range 31 to 87 years). Sixteen lumbar (35.6%) and 29 thoracic (64.4 %) levels were treated. Eighteen of the 30 patients had a history of cancer. Of these 18 cases, 13 procedures were for pathologic fractures, and 5 were for osteoporotic fractures (Table 1). In total, 17 procedures were for osteoporotic fractures. Pain duration ranged from 1 month to 5 years, with a mean of 10 months. The sex distribution was equal among the groups of patients with pathologic and osteoporotic fractures (Table 1).

SSPS, both at rest and with movement, was decreased significantly ($P < 0.0001$) in the immediate postoperative period and was sustained through to day 84 ($P < 0.0001$) (Figure 1, Table 2). The mean SSPS with movement was 8.7 preprocedure and 1.8 postprocedure, with a 12-week minimum follow-up. At Day 84, 24 of 27 patients had a decrease in SSPS of 2 or more, both at rest and with movement. Three patients had no response or only minimal improvement in pain. The SSPS for both the separated osteoporotic fractures and the pathologic fractures showed significant improvement in back pain after the procedure ($P = < 0.0001$) (Table 2). Overall, there was a trend to reduced analgesic consumption ($P < 0.0599$) (Table 2). This reduced analgesic consumption becomes significant in patients with osteoporotic fractures ($P < 0.0008$) when they are separated from patients with pathologic fractures ($P < 0.7471$).

A statistically significant overall improvement in quality of life ($P < 0.0004$) for both osteoporotic fractures and pathologic fractures was noted at Week 12 post-PVP. However, stratification showed that patients with osteoporotic fractures had a significantly greater quality-of-life improvement than did patients with pathologic fractures (Table 2, Table 3).

The stratified analysis by fracture type showed a difference in the degree of improvement between pathologic and osteoporotic fractures for quality-of-life measures (that is, nausea, tiredness, depression, anxiety, appetite, well-being, and shortness of breath) and pain with movement (SSPS). There

Table 2 Postprocedure *P* values for SSPS, ESAS, morphine equivalents, and TFAS, stratified by fracture type at follow-up

	Day 1	Day 84		
	All	All	Osteoporotic fracture	Pathologic fracture
SSPS, with movement	< 0.0001	< 0.0001	< 0.0001	< 0.0001
SSPS, at rest	< 0.0001	< 0.0001	< 0.0001	< 0.0001
General pain	< 0.0001	0.0004	0.001	0.2428
Nausea	0.001	< 0.0001	< 0.0001	0.0491
Tiredness	0.0014	0.0002	0.0035	0.0176
Depression	0.0043	< 0.0001	0.0146	< 0.0001
Anxiety	0.0007	< 0.0001	0.0002	0.0011
Drowsiness	< 0.0001	< 0.0001	0.0014	< 0.0001
Appetite	0.0011	0.0003	0.015	0.0076
Well-being	< 0.0001	< 0.0001	< 0.0001	0.0067
Shortness of breath	0.0166	< 0.0001	0.0004	0.1378
Morphine equivalents	0.6646	0.0599	0.0008	0.7471
TFAS	0.01	0.002	0.058	0.2231

ESAS = Edmonton Symptom Assessment System; SSPS = site-specific pain score; TFAS = Townsend Functional Assessment Scale.

Table 3 Stratified analysis by fracture type: osteoporotic, compared with cancer, fractures

Domain	*P*
General pain	0.9639
Nausea	0.0209
Tiredness	0.0028
Depression	< 0.0001
Anxiety	0.0062
Drowsiness	0.4334
Appetite	0.0001
Well-being	0.0049
Shortness of breath	< 0.0001
Pain at rest	0.4633
Pain with movement	0.0045
Morphine equivalents	0.2558

was no significance by fracture type for pain at rest (SSPS), morphine equivalents, general pain, or drowsiness (Table 3).

The TFAS at 12 weeks demonstrated significant improvement in mobility ($P < 0.002$). The results of the TFAS by fracture type suggested no difference between pre- and postoperative functional status. However, the *P* value for the osteoporotic patients was close to the conventional level of statistical significance ($P = 0.0580$), suggesting a probable improvement in mobility.

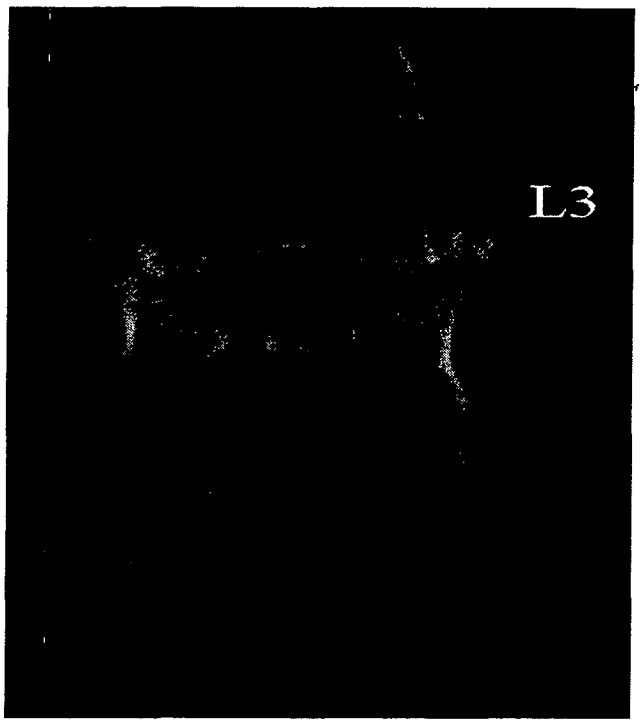
Subsequent Procedures and Complications

Cement extravasation was noted in 25 of 45 levels (55.6%). Extravasation sites include anterolateral or perivertebral soft tissues in 10 levels, superior or inferior disc space in 19 levels, and paravertebral veins in 2 levels; the epidural space of the spinal canal was encountered in 3 levels. Some levels had more than one type of cement extravasation. No neural foraminal extravasation of cement was noted.

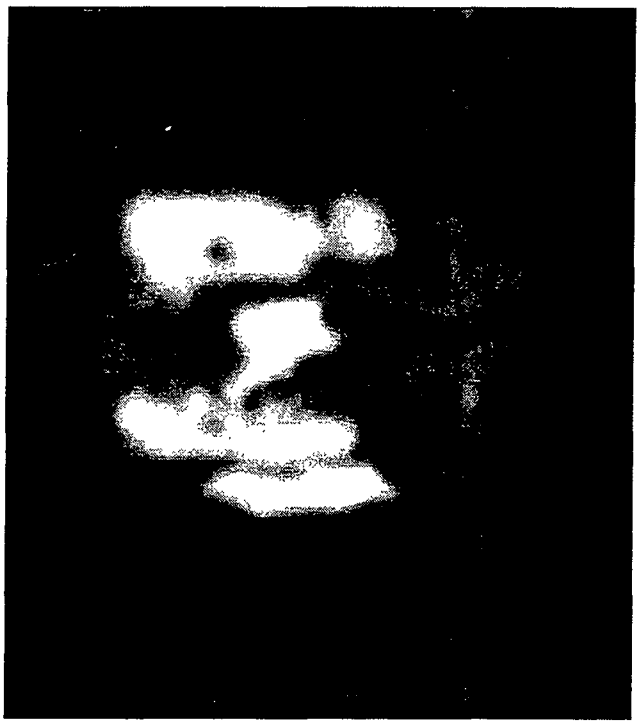
One additional patient required surgical decompression of cement from the spinal canal; this was related to extravasation of cement through the epidural veins that caused spinal cord

Figure 2 A and B Percutaneous vertebroplasty (PVP) at L3 and L4 in an osteoporotic woman, aged 72 years.

A: Coronal computed tomography (CT) scan of healed inferior endplate fracture of L3 and chronic unhealed L4 compression fracture



B: Post PVP at L3 and L4 with extravasation of cement into the L3-4 and L4-5 disc space via the superior and inferior endplate fractures of L4



compression. The extravasation was not appreciated because of the significantly increased bone density and difficulty of injecting into an osteoblastic metastasis. The patient had a stable mild posterior column deficit as a result of the extravasation. Her SSPS at rest improved from 8 prior to the procedure to 6 immediately after the procedure, but her SSPS with movement was unchanged (10/10), as was her TFAS score. Another patient had intradiscal extravasation of cement resulting in a disc herniation a few days later and recurrent new low back pain (Figure 2). The original pain was improved.

Two preterminal patients with metastatic disease died as a result of their primary disease at Weeks 2 and 4, prior to their 12-week follow-up. There were no deaths directly related to PVP treatment. One patient withdrew at Week 4. All 3 of these patients had reported significant, almost immediate, improvements in their ESAS score and SSPS that appeared sustained to their latest follow-up.

As noted above, 3 of the 30 patients underwent a subsequent vertebroplasty procédure at a different time. Two were for new adjacent fractures, and one was for a nonadjacent metastasis. Even though all 3 patients benefited from their second procedure, showing significant relief of pain, only the initial procedure was included in data analysis so that the data would not be skewed.

Discussion

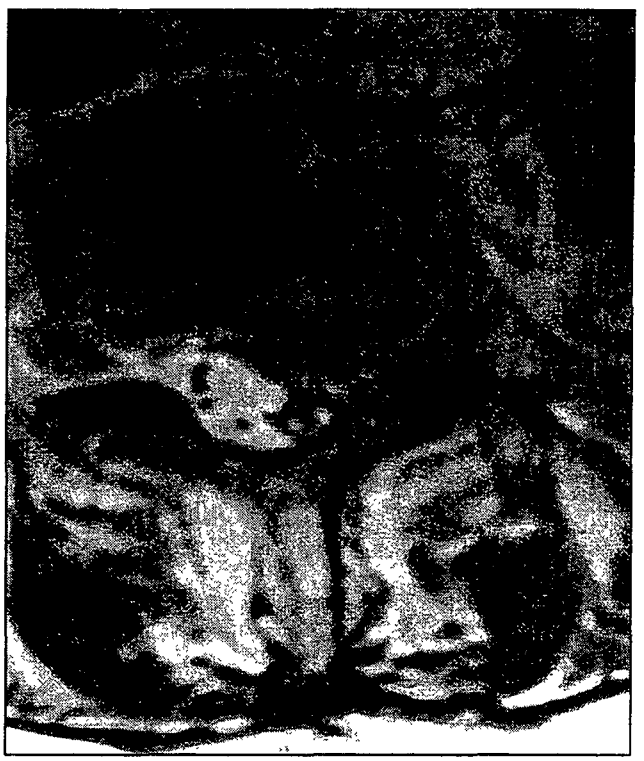
Only a handful of studies evaluate the quality of life after PVP, and even fewer prospective studies evaluate patients' quality of life, pain, and function before and after the procedure.[12,13,16,20] None of the published prospective studies include PVP of pathologic fractures. Our paper is unique in that our prospective quality-of-life study includes a comparison of both osteoporotic and pathologic fractures. We include both types of fractures to provide data that can be generalized to all types of fractures seen for PVP in Canada.

The largest published prospective study evaluating quality of life consists of 46 patients with 66 treated osteoporotic vertebral body fractures.[13] Pain and quality of life improved significantly, as evaluated by the Osteoporosis Quality of Life Questionnaire; improvement was maintained for at least 6 months after PVP. This is comparable to our study, the results of which demonstrate significant and almost immediate postprocedural improvement in pain, as judged by the ESAS, global pain measure, and SSPS. Concordant with the improvement in pain, patients reported significant improvements in all other ESAS domains. The patients' overall sense of well-being, depression, anxiety, and appetite appears to be attributed to a marked decrease in pain severity. The improvement in quality-of-life scores was sustained during our 12-week follow-up.

Figure 2 C and D Patient developed new left radicular pain 1 week later. Sagittal and axial T_1-weighted magnetic resonance (MR) image shows a new large left central L4-5 extrusion (black arrow). Note the dark signal (representing cement) within the L4-5 disc

C

D



The literature shows that significant pain relief is afforded in 70% to 80% of patients with pathologic fractures and in more than 90% of patients with osteoporotic fractures.[2,21,22] Pain relief is apparent within 1 to 2 days and seems to persist over months to years.[23,24] Our data are consistent with the literature showing that PVP provides significant immediate (within 1 day) and short-term (up to 12 weeks) pain relief. Matin found that fractures of longer than 6 months' duration typically do not benefit from vertebroplasty,[25] although this was not our experience. One patient had experienced intractable pain for 5 years but still had complete pain relief after the procedure. Fractures more than 1 year old can benefit from PVP, but complete pain relief is more likely with less mature fractures.[26]

Since many of our patients had significant comorbidities, including cancer with multiple bone metastases, we evaluated not only their global pain, using the ESAS, but also site-specific back pain related to their specific fracture or fractures. Not only did our results demonstrate a dramatic reduction in SSPS following the procedure, overall global pain also showed significant improvement, which may indicate the extent to which the patients' presenting local vertebral symptoms were a significant component of their overall global perception of pain. Although not statistically significant, there was a trend for decreased intake of analgesics, as measured by morphine equivalents. This simply reflects the high number of patients in this series (13/30) who had an underlying diagnosis of cancer with a pathologic fracture. This is borne out when we analyze the decrease in analgesic intake among the patients with pathologic fractures ($P < 0.7471$) separately from those with osteoporotic fractures ($P < 0.0008$). Patients who present with bony metastasis often present late in their disease course and have a high baseline narcotic requirement for their multiple bony metastases. Following the procedure, the cancer patients were able to function and move more comfortably at similar or slightly lower dosages; however, many could not be weaned off their pain medications, unlike the osteoporotic fracture patients. The cancer patients had multiple bone metastases causing site-specific pain or other pain, such as visceral pain Reduction of pain from the most painful site often unmasked pain from other sites, necessitating continuation of their analgesics.

Both osteoporotic patients and pathologic fracture patients demonstrate significant improvement in quality-of-life scores. This is no doubt related to the significant decrease in back pain. One might also anticipate that a lower intake of analgesics would contribute to an improved perception of quality of life as reflected by less drowsiness and nausea and improved appetite. When the data are stratified by fracture type, it is apparent that osteoporotic patients enjoy an even greater improvement in

quality of life than do cancer patients, largely because this is their only source of pain.

The TFAS demonstrates significant improvement in patient mobility after the procedure. The significance is diminished when the sample is subdivided into fracture type, presumably because of a significantly smaller sample size. Not only is mobility improved, many patients note better posture and increased body height, related to partial restoration of vertebral body height with PVP. This was recently reported to occur in about one-third of PVP-treated vertebral bodies (23/65).

Cohort studies have demonstrated that PVP can provide significant and rapid pain relief with relatively low complication rates of 1% to 10%.[11,12,16,28–31] Complications are minor, relatively infrequent, and usually transient; however, there are anecdotal reports of cord compression, transient worsening of pain, radicular pain, infection, adjacent vertebral fracture, and spinal cord compression.[32] Rarely, pulmonary or paradoxical cerebral arterial embolization from cement leakage into the epidural veins can occur.[33–35]

Extravertebral extrusion of polymethyl methacrylate (PMMA) is common, seen in up to 73% (29/40) of patients with metastatic disease.[36] Although this series reported 2 of 37 patients requiring decompression back surgery for significant nerve root compression, most series report no clinical sequelae of cement leakage. There is a reported higher complication rate of approximately 10% with pathologic fractures, often related to loss of the posterior vertebral cortex or displacement of tumour into the spinal canal. There is a lower complication rate of approximately 1% with osteoporotic fracture. We had 2 major complications, one in a pathologic fracture patient and one in an osteoporotic fracture patient. The first complication occurred in a patient with a vertebral osteoblastic metastasis that experienced extravasation of cement into the canal with cord impingement and mild sensory changes (posterior column deficit). Interestingly, the patient's back pain showed improvement immediately after the PVP. Her spinal canal was surgically decompressed the next day with no change in her mild sensory deficit. The second complication occurred in an osteoporotic patient who had intradiscal extravasation of cement resulting in a disc herniation and new radicular pain (Figure 2). We also had 2 cases of postoperative adjacent vertebral fractures that were treated successfully with a subsequent PVP. It is not clear whether these fractures were related to the observed cement leakage into the intervertebral disc space or to other unrelated factors.[37,38]

This study has several limitations, including a varied patient population, small sample size, and relatively short follow-up period. The varied patient population may have muddied the results; however, this allowed for a direct comparison of the differences in improvement between osteoporotic and pathologic fractures. It was also our goal to reflect the experience of a single operator in a Canadian tertiary care referral centre and the generalizability of the results across both patient populations. The small numbers of referrals generally include a high percentage of cancer patients and are typical of a Canadian centre.

That all the procedures were performed by a single operator may be considered a sampling limitation since these results may not be achievable by others. Nonetheless, excellent results can be achieved in competent hands.

The ESAS and TFAS were designed for the palliative patient population, and their generalizability to the osteoporotic population has not been validated.[19] PVP was in its infancy in Canada at the beginning of this study. At this time, we felt that most eligible patients would have pathologic fractures and decided that the best quality-of-life assessment scales would be those used in the palliative care patient population. Given our mixed population, we did not feel that osteoporosis assessments such as the Osteoporosis Quality of Life Questionnaire were appropriate. We also felt that our osteoporotic fracture patients would behave much like the palliative care population because of the selection criteria of intractable pain. The categorical data of the TFAS are also less precise when compared with the continuous data. The advantage of the above scales and of the SSPS is their simplicity, which allows us to use telephone follow-up instead of more problematic in-person follow-up sessions.[39] The simplicity of the verbal rating scale of the SSPS also saves time and compares favourably with the Visual Analog Scale for pain used in many vertebroplasty papers.[21]

A significant shortcoming of this study is the lack of a control group. Although we do not know for certain whether our patients would have improved without PVP, our inclusion criteria limited this possibility. For pathologic fractures, we included only those patients who had failed radiation therapy. Our osteoporotic fracture patients were all well beyond the normal healing time frame, including one patient who had experienced chronic pain for 5 years. Also, because of the difficulty in conducting them, the literature contains no controlled prospective trials.

In summary, PVP significantly improved patient perception of quality of life and function by markedly decreasing axial spinal pain. The almost immediate effects of PVP on symptoms and patient-derived quality-of-life assessments appeared to be sustained in early-term follow-up (12 weeks). Stratification by fracture type shows that patients with osteoporotic fractures performed better after PVP, on average, than did the patients with pathologic fractures. Although cement extravasation is a relatively frequent occurrence (55.6%), the risk of significant clinical sequelae is low. The long-term efficacy of the technique requires further study.

References

1. Galibert P, Deramond H, Rosat P, Le Gars D. [Preliminary note on the treatment of vertebral angioma by percutaneous acrylic vertebroplasty]. *Neurochirurgie* 1987;33:166–8.
2. Barr JD, Barr MS, Lemley TJ, McCann RM. Percutaneous vertebroplasty for pain relief and spinal stabilization. *Spine* 2000;25:923–8.
3. Alvarez L, Perez-Higuera A, Granizo JJ, et al. Predictors of outcomes of percutaneous vertebroplasty for osteoporotic vertebral fractures. *Spine* 2005;30:87–92.
4. Jensen ME, Kallmes DE. Percutaneous vertebroplasty in the treatment of malignant spine disease. *Cancer J* 2002;8:194–206.
5. Weill A, Chiras J, Simon JM, et al. Spinal metastases: indications for and results of percutaneous injection of acrylic surgical cement. *Radiology* 1996;199:241–7.
6. Cortet B, Cotten A, Boutry N, et al. Percutaneous vertebroplasty in patients with osteolytic metastases or multiple myeloma. *Rev Rhum Engl Ed* 1997;64:177–83.
7. Martin JB, Jean B, Sugiu K, et al. Vertebroplasty: clinical experience and follow-up results. *Bone* 1999;25:11S–15S.
8. Yamada K, Matsumoto Y, Kita M, et al. Long-term pain relief effects in four patients undergoing percutaneous vertebroplasty for metastatic vertebral tumor. *J Anesth* 2004;18:292–5.
9. Cohen JE, Lylyk P, Ceratto R, et al. Percutaneous vertebroplasty: technique and results in 192 procedures. *Neurol Res* 2004;26:41–9.
10. Vasconcelos C, Gailloud P, Beauchamp NJ, et al. Is percutaneous vertebroplasty without pretreatment venography safe? Evaluation of 205 consecutives procedures. *AJNR Am J Neuroradiol* 2002;23:913–7.
11. McGraw JK, Lippert JA, Minkus KD, et al. Prospective evaluation of pain relief in 100 patients undergoing percutaneous vertebroplasty: results and follow-up. *J Vasc Interv Radiol* 2002;13:883–6.
12. Zoarski GH, Snow P, Olan WJ, et al. Percutaneous vertebroplasty for osteoporotic compression fractures: quantitative prospective evaluation of long-term outcomes. *J Vasc Interv Radiol* 2002;13:139–48.
13. McKiernan F, Faciszewski T, Jensen R. Quality of life following vertebroplasty. *J Bone Joint Surg Am* 2004:86-A(12):2600-6.
14. Alvarez L, Perez-Higueras A, Quinones D, et al. Vertebroplasty in the treatment of vertebral tumors: postprocedural outcome and quality of life. *Eur Spine J* 2003;12:356–60.
15. Legroux-Gerot I, Lormeau C, Boutry N, et al. Long-term follow-up of vertebral osteoporotic fractures treated by percutaneous vertebroplasty. *Clin Rheumatol* 2004;23:310–7.
16. Perez-Higueras A, Alvarez L, Rossi RE, et al. Percutaneous vertebroplasty: long-term clinical and radiological outcome. *Neuroradiology* 2002;44:950–4.
17. Bruera E, Kuehn N, Miller MJ, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7:6–9.
18. Townsend PW, Rosenthal HG, Smalley SR, et al. Impact of postoperative radiation therapy and other perioperative factors on outcome after orthopedic stabilization of impending or pathologic fractures due to metastatic disease. *J Clin Oncol* 1994;12:2345–50.
19. Chang VT, Hwang SS, Feuerman M. Validation of the Edmonton Symptom Assessment Scale. *Cancer* 2000;88:2164–71.
20. Chow E, Holden L, Danjoux C, et al. Successful salvage using percutaneous vertebroplasty in cancer patients with painful spinal metastases or osteoporotic compression fractures. *Radiother Oncol* 2004;70:265–7.
21. Evans AJ, Jensen ME, Kip KE, et al. Vertebral compression fractures: pain reduction and improvement in functional mobility after percutaneous polymethlmethacrylate vertebroplasty retrospective report of 245 cases. *Radiology* 2003;226:366–72.
22. Jensen ME, Evans AJ, Mathis JM, et al. Percutaneous polymethylmethacrylate vertebroplasty in the treatment of osteoporotic vertebral body compression fractures: technical aspects. *AJNR Am J Neuroradiol* 1997;18:1897–904.
23. Grados F, Depriester C, Cayrolle G, et al. Long-term observations of vertebral osteoporotic fractures treated by percutaneous vertebroplasty. *Rheumatology (Oxford)* 2000;39:1410–4.
24. Heini PF, Walchli B, Berlemann U. Percutaneous transpedicular vertebroplasty with PMMA: operative technique and early results. A prospective study for the treatment of osteoporotic compression fractures. *Eur Spine J* 2000;9:445–50.
25. Matin P. Bone scintigraphy in the diagnosis and management of traumatic injury. *Semin Nucl Med* 1983;13:104–22.
26. Brown DB, Gilula LA Sehgal M, Shimony JS. Treatment of chronic symptomatic vertebral compression fractures with percutaneous vertebroplasty. *AJR Am J Roentgenol* 2004;182:319–22.
27. McKiernan F, Faciszewski T, Jensen R. Reporting height restoration in vertebral compression fractures. *Spine* 2003;28:2517–21.
28. Nakano M, Hirano N, Matsuura K, et al. Percutaneous transpedicular vertebroplasty with calcium phosphate cement in the treatment of osteoporotic vertebral compression and burst fractures. *J Neurosurg* 2002;97:287–93.
29. Kallmes DF, Schweickert PA, Marx WF, Jensen ME. Vertebroplasty in the mid- and upper thoracic spine. *AJNR Am J Neuroradiol* 2002;23:1117–20.
30. Chen JF, Lee ST, Lui TN, et al. Percutaneous vertebroplasty for the treatment of osteoporotic vertebral compression fractures: a preliminary report. *Chang Gung Med J* 2002;25:306–14.
31. Amar AP, Larsen DW, Esnaashari N, et al. Percutaneous transpedicular polymethylmethacrylate vertebroplasty for the treatment of spinal compression fractures. *Neurosurgery* 2001;49:1105–14; discussion 1114–5.
32. Cortet B, Cotten A, Boutry N, et al. Percutaneous vertebroplasty in the treatment of osteoporotic vertebral compression fractures: an open prospective study. *J Rheumatol* 1999;26:2222–8.
33. Padovani B, Kasriel O, Brunner P, Peretti-Viton P. Pulmonary embolism caused by acrylic cement: a rare complication of percutaneous vertebroplasty. *AJNR Am J Neuroradiol* 1999;20:375–7.
34. Scroop R, Eskridge J, Britz GW. Paradoxical cerebral arterial embolization of cement during intraoperative vertebroplasty: case report. *AJNR Am J Neuroradiol* 2002;23:868–70.
35. Jang JS, Lee SH, Jung SK. Pulmonary embolism of polymethylmethacrylate after percutaneous vertebroplasty: a report of three cases. *Spine* 2002;27:E416–8.
36. Cotten A, Dewatre F, Cortet B, et al. Percutaneous vertebroplasty for osteolytic metastases and myeloma: effects of the percentage of lesion filling and the leakage of methyl methacrylate at clinical follow-up. *Radiology* 1996;200:525–30.
37. Uppin AA, Hirsch JA, Centenera LV, et al. Occurrence of new vertebral body fracture after percutaneous vertebroplasty in patients with osteoporosis. *Radiology* 2003;226:119–24.
38. Kim SH, Kang HS, Choi JA, Ahn JM. Risk factors of new compression fractures in adjacent vertebrae after percutaneous vertebroplasty. *Acta Radiol* 2004;45:440–5.
39. Cork RC, Isaac I, Elsharydah A, Saleemi S, Zavisca F, Alexander L. A comparison of the verbal rating scale and the visual analog scale for pain assessment. The Internet Journal of Anesthesiology 2004:8(1). Available: www.ispub.com/ostia/index.php?xmlFilePath=journals/ija/vol8n1/vrs.xml. Accessed 2006 Feb 16.

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Evaluation of Vertebroplasty with a Validated Outcome Measure: The Roland-Morris Disability Questionnaire

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BACKGROUND AND PURPOSE: **Vertebroplasty is rapidly disseminating as a treatment for vertebral compression fractures, but its efficacy has not been assessed with a well-validated, back pain–specific instrument. We report the use of the Roland-Morris Disability Questionnaire (RDQ) in patients undergoing vertebroplasty for painful osteoporotic compression fractures.**

METHODS: **Retrospective review of patients treated with vertebroplasty who completed the RDQ and 2 verbal pain scales (0–10) for pain at rest and pain with activity at baseline, 1 week, 1 month, 6 months, and 1 year post-vertebroplasty. Changes in outcome measures were analyzed by using a paired *t* test and correlations were assessed with Spearman ρ. Multiple linear regression was used to analyze the relationship between baseline scores and independent variables.**

RESULTS: **One hundred thirteen patients were treated at 164 vertebral levels. At baseline, RDQ scores were associated with rest and activity pain ($P < .001$ and $P = .002$, respectively) but were not associated with other independent variables. All 3 outcome scores decreased by 1 week and remained improved through maximal follow-up ($P < .001$). RDQ scores improved by a mean of 7.0 points at 1 week and remained improved at 1 year ($P = .02$). RDQ scores correlated with both rest and activity pain, but the absolute correlation was slightly better (+0.15 on average) with activity pain.**

CONCLUSIONS: **Patients who underwent vertebroplasty experienced relief of back pain and symptoms, as shown by improvement in verbal pain and RDQ scores. The RDQ correlates well with measures of pain, shows clinically significant improvement and is responsive to changes across time. More important, the RDQ provides an easily administered, well-validated, back pain–specific outcome measure that could be adopted to assess vertebroplasty outcomes.**

First used in the United States in the 1990s, vertebroplasty has rapidly approached standard of care for treatment of medically refractory, painful vertebral compression fractures. Because of difficulties in study design and execution there have been no randomized, blinded, controlled studies comparing vertebroplasty to placebo or conservative therapies. Instead, investigators have sought to validate use of the procedure through changes in measures of perceived pain. These studies have shown significant improvement in pain and other symptoms as assessed by these instruments (1–3). There is no continuity, however, in the type of instrument used or the symptom variables that have been assessed in the vertebroplasty literature.

A critical review of the vertebroplasty literature reveals that, to this point, there exists a dearth of studies that have used validated outcome measures to assess the efficacy of this treatment. Visual analog scoring of perceived pain is the most common method of assessment. Although this addresses the patient's pain and provides a well-validated variable for assessment of pain control (4), this instrument fails to address the other symptoms and disabilities experienced by the patient. Because vertebroplasty aims at improving both the pain and disability experienced by the patient, both of these elements should be in-

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cluded in outcome measures when determining treatment efficacy.

We report the application of a widely applied, back pain–specific, well-validated outcomes instrument, the Roland-Morris Disability Questionnaire (RDQ), to a consecutive cohort of patients undergoing vertebroplasty for the treatment of painful, osteoporotic compression fractures. In addition, we correlated the RDQ with 2 11-point graded pain scales and tracked these measures across time. We believe that the RDQ should be used as the primary outcome measure for vertebroplasty research and practice.

Methods

We performed a retrospective review of 113 patients who underwent vertebroplasty between April 21, 2003, and September 27, 2004, at our institution. Institutional review board approval was obtained for this study. Vertebroplasty typically was offered to patients with radiologic evidence of acute or subacute vertebral compression fractures of thoracic or lumbar vertebrae. Exclusion criteria included improvement with conservative management, technical contraindications, and noncorrelating pain. Patients included in this study were limited to those with compression fractures due to underlying osteoporosis.

Vertebroplasty Procedure

Vertebroplasties were performed by staff radiologists according to the methods outlined previously (5). Specifically, patients were treated by using intravenous conscious sedation. Biplane fluoroscopy was used in all cases. Local anesthesia was administered over the skin, subcutaneous tissues, muscular tissues, and periosteum of the targeted pedicle. Transpediculate or parapedicular trajectories were used in all cases. After local anesthetic administration, 11- or 14-gauge biopsy needles (Cook Inc., Bloomington, IN) were advanced into the central aspect of the vertebral bodies for unipediculate approaches, whereas placement of the needle was made into the midportion of the hemivertebra for bipediculate approaches.

The polymethylmethacrylate (PMMA) cement mixture was prepared under a vacuum hood. Approximately 30 g of PMMA powder (Codman Cranioplastic, Raynham, MA) was mixed with 12 g sterile barium sulfate (Cardinal Health, McGaw Park, IL) and 1 g gentamicin powder (Hawkins Inc., Minneapolis, MN). Liquid PMMA monomer was mixed with the powder mixture until the fluid reached a viscosity similar to that of cake glaze. The mixture was then loaded either into an injector device (Cook Inc.) or into 1-mL syringes and injected under continuous lateral and intermittent AP fluoroscopy. Cement injection was considered complete when the cement reached the posterior fourth of the vertebral body on the lateral projection. Injection was also terminated when epidural, venous, or transendplate extravasation was noted. Following needle removal, patients were left on strict bed rest for 1 hour and then discharged.

A maximum of 4 vertebral levels were treated in a single session based on clinician comfort levels. Additional levels were treated in repeat sessions as required.

Outcome Measures

The RDQ (appendix 1) and 2 verbal scales (scored 0–10) to assess "pain at rest" and "pain with activity" were administered in person by trained nurses at the time of evaluation for vertebroplasty. The original RDQ contained 24 questions and was derived from statements contained in the Sickness Impact Profile (6). Each question was selected on the basis of its likelihood of being influenced by back pain and the qualification "because of my back pain" was added to further target the responses (7). The modified RDQ used in this study is that proposed by Patrick et al (8) and contains 23 yes/no questions. Nineteen of these 23 items are taken from the original RDQ, and 4 were derived from other statements in the Sickness Impact Profile (8). These modifications were suggested by the authors in an effort to reduce redundancy and add in items that were previously shown to better reflect changes in patient condition (8). The modified instrument takes approximately 3 minutes to complete and can be self-administered or administered via the telephone. It is scored from 0 to 23 on the basis of the number of "yes" responses. The authors have demonstrated that the modified version had a high level of internal consistency, construct validity, and responsiveness (8).

Follow-up data for all 3 outcome scales were gathered by telephone by the same trained nurses at 1 week, 1 month, 6 months, and 1 year post-vertebroplasty. Patients who were telephoned 3 times, without successfully obtaining follow-up data, were designated as nonrespondents for that time period. Nonrespondent status at a given time point did not preclude contacting that patient at the next designated time point.

Statistical Analysis

Changes in pain scores across time were analyzed by using a paired t test comparison to the preceding time point. Correlation between outcome measures was assessed with the Spearman ρ correlation coefficient and differences in the strength of correlation were assessed through statistical bootstrapping of the data. Multiple linear regression was used to analyze the relationship between outcome scores and independent variables (age, sex, lumbar versus thoracic treatment, number of levels treated) at baseline and 1 week.

Results

Data were collected from 113 patients who underwent vertebroplasty at 164 vertebral levels. Compression fractures in this population were all osteoporotic in origin. The mean patient age at the time of the procedure was 74 years (range, 28–96 years). Ninety (80%) of the 113 patients were women. As of this study, 113 patients were immediately post-vertebroplasty, 108 (96%) patients 1 week post-vertebroplasty, 93 (82%) patients 1 month post-vertebroplasty, 52 (46%) patients 6 months post-vertebroplasty, and 19 (17%) patients 1 year post-vertebroplasty. RDQ scores were available for 108 (96%) patients at baseline, 93 (86%) patients at 1 week, 73 (79%) patients at 1 month, 46 (89%) patients at 6 months, and 15 (79%) patients at 1 year. Four patients were excluded at 1 year because of secondary injury or processes that may have skewed their RDQ scores. Three of the excluded patients had falls resulting in pelvic fractures in one and new vertebral fractures in another. The fourth patient was excluded because of a subsequent diagnosis of fibromyalgia as the cause of her pain.

All 3 outcome measures (rest pain, activity pain, and RDQ score) showed a significant decrease at 1 week ($P < .001$), with RDQ scores improving by a mean of 7.0 points. These improvements in all 3 outcome measures persisted through 1-year follow-up (Fig 1). Absolute values continued to decline at each time point, but the changes between time points were not statistically significant. There was a statistically

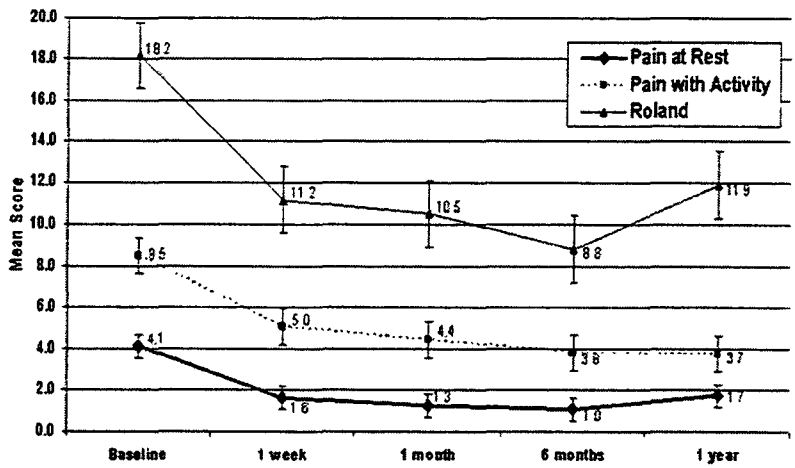

FIG 1. Mean RDQ and pain scores, with SDs, across follow-up. There is significant improvement in all 3 outcome measures at 1 week that persists throughout follow-up.

TABLE 1: Correlation between Roland score and pain scales at each time point throughout follow-up

	Pain at Rest	Pain with Activity
Baseline	0.30	0.47
1 week	0.57	0.52
1 month	0.44	0.40
6 months	0.31	0.63

TABLE 2: Linear regression of baseline Roland and pain with activity scores

Covariate	Roland	Baseline, Pain with Activity	Baseline, Pain at Rest
Baseline			
Pain with activity	<.001		.06
Pain at rest	.002	.06	
Roland score		<.001	.04
Age	.09	.58	.30
Sex (male)	.06	.20	.99
Level			
Lumbar	.50	.38	.12
Thoracic	.64	.29	.18
Number of levels treated	.45	.43	.35

Note.—Columns indicate *P* values.

significant increase in RDQ scores at 1 year (P = .003), but the score remained significantly improved over that at baseline (P = .02).

RDQ scores correlated with both rest pain and activity pain at all time points (Table 1). On average, the correlation between RDQ scores and activity pain scores was +.15 better than that with rest pain scores. This difference approached but did not reach statistical significance (P = .07).

Multiple linear regression analysis of outcome measures showed an association between baseline RDQ scores and baseline activity pain and rest pain (P < .001 and P = .002, respectively) but showed no significant correlation with other patient or procedural variables (Table 2). Scores at 1 week were not found to be associated with baseline scores or any of the other variables.

Discussion

Although vertebroplasty is rapidly disseminating as a treatment for vertebral compression fractures, the evidence for efficacy is weighed largely on symptomatic improvement in perceived pain from case series. Although pain control is an important element of vertebroplasty, the procedure is also designed to reduce disability in the treated individual. Few investigations have used validated outcome measures to address the impact of vertebroplasty on patient disability.

In the current study, we applied the RDQ to the practice of vertebroplasty. We selected the RDQ because it fulfills criteria that are important for outcome measures used to evaluate the efficacy of vertebroplasty: (1) back pain-specific measurement; (2) well validated in the literature; and (3) easily administered by telephone to elderly patients. The RDQ was specifically designed to assess physical disability due to lower back pain (6). In addition, this instrument was determined to be reliable and well validated when it was initially proposed and has been validated in many studies since that time (7, 9).

We showed substantial improvement in RDQ scores that persisted with time. Mean improvements were on the order of 7–9 points at all follow-up intervals. This level of improvement far exceeds the change of 2–3 points that is considered clinically important by the authors of the instrument (7). Further, we showed that RDQ scores correlate with the well-established 11-point verbal pain scales frequently used in the literature. Both RDQ scores and pain scale measurements improved significantly at 1 week and remained improved over baseline through 1-year follow-up. Last, we found the RDQ instrument to be highly user-friendly, generating acceptable response rates and facilitating telephone follow-up with vertebroplasty patients. These findings are relevant because they show that the RDQ is well suited to measure vertebroplasty outcomes as it is both sensitive to change across time and correlates well with the patient's level of pain and disability.

Previous authors have applied a variety of validated outcomes scales to vertebroplasty and have shown

TABLE 3: Results of previous outcome measure studies

Study	*n*	Instrument	Result
Zoarski et al (18)	30 patients, 54 fractures	MODEMS (includes SF-36)	Improvement in all 4 MODEMS modules ($P < .0001$, $P < .0001$, $P < .0004$, $P < .0009$)
Perez-Higueras et al (19)	13 patients, 37 fractures	McGill-Melzack Pain Questionnaire	Improvement in scores following treatment ($P < .001$), but worsening at follow-up (mean of 65 months)
Legroux-Gerot et al (12)	16 patients, 21 fractures	McGill-Melzack Pain Questionnaire	Decrease in scores at 6 months with no change through maximal follow-up (mean of 35 months) ($P < .05$)
		Nottingham Health Profile	Decrease in quality of life ($P = .05$); increase in social isolation ($P < .05$), otherwise no change
Cortet et al (20)	16 patients, 20 fractures	McGill-Melzack Pain Questionnaire	Decrease in score at days 3, 30, 90, and 180 (all $P < .005$)
		Health Profile	Decrease in 5 of 6 dimensions ($P < .001$, $P < .05$, $P < .05$, $P < .05$), not sleep
Winking et al (14)	38 patients	ODI	Decrease in mean score at day 2, which persisted to 6 weeks ($P < .01$)

Note.—MODEMS indicates Musculoskeletal Outcomes Data Evaluation and Management Scale; ODI, Oswestry Low Back Pain Disability Questionnaire.

improvement in measured disability and symptoms (Table 3). With the exception of the Oswestry Low Back Pain Disability Questionnaire (ODI), however, these instruments do not focus on the most relevant criteria in tracking outcomes in vertebroplasty patients. Back pain specificity is the most important of these criteria. Many of the patients who receive vertebroplasty have coincident health problems that influence their overall level of health and functioning. Back pain and symptom data that are gathered through global health measures are likely confounded by the influence of other health conditions on these assessments.

The SF-36, McGill Mezlack questionnaire, and Nottingham Health Profile were designed as generic measurements of health and are not specific to back pain (10–12). It is important to note that the RDQ shows more responsiveness to change than the SF-36 and thus may be more useful in assessing outcomes (13). Also the McGill Mezlack questionnaire is more complex than other instruments both to administer and to score.

The ODI might be considered to be the most appropriate instrument that has been previously used in the literature to assess outcomes after vertebroplasty. This instrument was specifically designed to describe back pain and disability and has been found to be both reliable and valid (7). It has also been effectively administered in person and by telephone. The only study in the literature to use the ODI in vertebroplasty outcomes assessment is the study by Winking et al (14), which enrolled 38 patients and tracked their outcomes for 1 year. The authors showed a significant decrease in ODI score 2 days postvertebroplasty that persisted unchanged to 6 weeks. Although ODI scores were tracked out to 1 year, statistics were only given on these data out to 6 weeks, and thus the authors could not comment on long-term outcomes.

Comparisons of the RDQ to the ODI have shown small but important differences. Stratford et al (9) found an increased rate of incomplete responses with the ODI when compared with the RDQ. This may be inherent in the instrument or may reflect the fact that the ODI has more questions specific to "sex life," "social life," and "travel," which may be less relevant in the day-to-day function of the elderly population. Regarding the applicability of the 2 instruments, Roland and Fairbank (7) concluded that the RDQ may be better suited to settings in which patients have mild to moderate disability that is expected to improve, whereas the ODI is suited to situations in which patients have persistent severe disability. These 2 conclusions lead us to believe that the RDQ is not only more appropriate in vertebroplasty patients who are expected to rapidly improve, but also may generate more complete responses and data.

In our practice, we have observed substantial clinical utility for the RDQ. Primarily, the RDQ is more useful than pain scores for assessment of the impact of vertebral fractures on the patient's daily life. Pain scores are influenced by the patient's perception and tolerance for pain and the reported value relates only loosely to functional limitation. The RDQ, however, gives care providers an objective assessment of the functional limitation suffered by the patient. This is useful both for the treating physician and for ancillary health staff. For the physician, thinking of RDQ scores in categories similar to those defined by Patrick et al (8)—10.8 = low; 15.7 = mild; 17.5 = moderate; 19.0 = severe—allows informal categorization of the severity of the patient's impairment and provides some basis for treatment and management decisions. For ancillary health staff, specific limitations indicated in the RDQ can provide a basis for physical/occupational therapy or other directed lifestyle interventions. Finally, tracking both specific items on the RDQ and the RDQ score in general, allows effective monitoring of a patient's progress following vertebroplasty.

Although our study is the first to apply the RDQ to

vertebroplasty patients and the first to show long-term improvement in a validated, back pain–specific outcome measure, several substantial limitations remain. This study was both retrospective and lacking a control group. Ultimately, to validate the efficacy of vertebroplasty, prospective controlled studies are needed to show significant improvement over conservative management (15). Another potential limitation to this study is that follow-up was done by telephone. Although we felt that one of the characteristics of a good outcome measure was ease of telephone administration, other investigators argue that administering an instrument by telephone introduces a bias to the data (16, 17). This is a valid concern, but the increased response rates and the ability for fragile and significantly disabled patients to complete the instrument outweigh the potential bias. In addition, we took steps to minimize this bias by having designated vertebroplasty nurses administer the RDQ in person and by telephone according to a strict protocol. The low response rate at 1 year is also problematic, with only 17% of subjects achieving that duration of follow-up by the time of this study. On the basis of the small data set, the results for 1 year may be less reliable than those at earlier time points. Finally, a potential issue with our data collection is that our nonrespondents were not carefully tracked. For the purpose of outcomes data, it would be useful to differentiate between patients who were unwilling or unable to complete the instrument versus those who were simply lost to follow-up.

This study undertook to address an underlying deficiency in the vertebroplasty literature and demonstrate the use of a validated outcome measure. It provides useful and valid data about vertebroplasty outcomes but does not preclude the necessity to undertake additional prospective, controlled studies. If we are to draw larger conclusions across studies and populations, it is important that we standardize our outcome assessments.

Conclusion

Patients undergoing vertebroplasty for osteoporotic compression fractures had less pain and symptoms after the procedure. On the basis of background data and the results of this study, the RDQ appears well suited as a standardized measure of the efficacy of vertebroplasty. It is longitudinally validated and back pain–specific, and we have shown it to be effective in assessing outcomes following vertebroplasty. It is our assertion that the RDQ should be adopted as the outcome measure of choice to monitor the long-term efficacy of vertebroplasty.

Appendix 1

Modified RDQ (6, 8)

When your back hurts, you may find it difficult to do some of the things that you normally do. This list contains sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. When you read a sentence that describes you today, put a tick against it. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only tick the sentence if you are sure it describes you today.

1. I stay at home most of the time because of my back
2. I change position frequently to try and get my back comfortable
3. I walk more slowly than usual because of my back
4. Because of my back I am not doing any of the jobs that I usually do around the house
5. Because of my back, I use a handrail to get upstairs
6. Because of my back, I have to hold on to something to get out of an easy chair
7. I get dressed more slowly than usual because of my back
8. I only stand up for short periods of time because of my back
9. Because of my back, I try not to bend or kneel down
10. I find it difficult to get out of a chair because of my back
11. My back is painful almost all the time
12. I find it difficult to turn over in bed because of my back
13. I have trouble putting on my sock (or stockings) because of the pain in my back
14. I only walk short distances because of my back pain
15. I sleep less well because of my back
16. I avoid heavy jobs around the house because of my back
17. Because of my back pain, I am more irritable and bad tempered with people than usual
18. Because of my back, I go upstairs more slowly than usual
19. I stay in bed most of the time because of my back
20. Because of my back problem, my sexual activity is decreased
21. I keep rubbing or holding areas of my body that hurt or are uncomfortable
22. Because of my back, I am doing less of the daily work around the house than I would usually do
23. I often express concern to other people about what might be happening to my health

References

1. Evans AJ, Jensen ME. Kip KE, et al. **Vertebral compression fractures: pain reduction and improvement in functional mobility after percutaneous polymethylmethacrylate vertebroplasty retrospective report of 245 cases.** *Radiology* 2003;226:366–372
2. McGraw JK, Lippert JA, Minkus KD, et al. **Prospective evaluation of pain relief in 100 patients undergoing percutaneous vertebroplasty: results and follow-up.** *J Vasc Interv Radiol* 2002;13:883–886
3. Diamond TH, Champion B. Clark WA. **Management of acute**

osteoporotic vertebral fractures: a nonrandomized trial comparing percutaneous vertebroplasty with conservative therapy. *Am J Med* 2003;114:257–265
4. Huskisson EC. **Measurement of pain.** *Lancet* 1974;2:1127–1131
5. Jensen ME, Evans AJ, Mathis JM, et al. **Percutaneous polymethylmethacrylate vertebroplasty in the treatment of osteoporotic vertebral body compression fractures: technical aspects.** *AJNR Am J Neuroradiol* 1997;18:1897–1904
6. Roland M, Morris R. **A study of the natural history of back pain. Part I. Development of a reliable and sensitive measure of disability in low-back pain.** *Spine* 1983;8:141–144
7. Roland M, Fairbank J. **The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire.** *Spine* 2000;25:3115–3124
8. Patrick DL, Deyo RA, Atlas SJ, et al. **Assessing health-related quality of life in patients with sciatica.** *Spine* 1995;20:1899–1908; discussion 1909
9. Stratford PW, Binkley J, Solomon P, et al. **Assessing change over time in patients with low back pain.** *Phys Ther* 1994;74:528–533
10. Ware JE Jr, Sherbourne CD. **The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection.** *Med Care* 1992;30:473–483
11. Melzack R. **The McGill Pain Questionnaire: major properties and scoring methods.** *Pain* 1975;1:277–299
12. Legroux-Gerot I, Lormeau C, Boutry N, et al. **Long-term follow-up of vertebral osteoporotic fractures treated by percutaneous vertebroplasty.** *Clin Rheumatol* 2004;23:310–317
13. Turner JA, Fulton-Kehoe D, Franklin G, et al. **Comparison of the Roland-Morris Disability Questionnaire and generic health status measures: a population-based study of workers' compensation back injury claimants.** *Spine* 2003;28:1061–1017; discussion 1067
14. Winking M, Stahl JP, Oertel M, et al. **Treatment of pain from osteoporotic vertebral collapse by percutaneous PMMA vertebroplasty.** *Acta Neurochir (Wien)* 2004;146:469–476
15. Jarvik JG, Kallmes DF, Mirza SK. **Vertebroplasty: learning more, but not enough.** *Spine* 2003;28:1487–1489
16. Weinberger M, Oddone EZ, Samsa GP, et al. **Are health-related quality-of-life measures affected by the mode of administration?** *J Clin Epidemiol* 1996;49:135–140
17. Guyatt GH, Feeny DH, Patrick DL. **Measuring health-related quality of life.** *Ann Intern Med* 1993;118:622–629
18. Zoarski GH, Snow P, Olan WJ, et al. **Percutaneous vertebroplasty for osteoporotic compression fractures: quantitative prospective evaluation of long-term outcomes.** *J Vasc Interv Radiol* 2002;13:139–148
19. Perez-Higueras A, Alvarez L, Rossi RE, et al. **Percutaneous vertebroplasty: long-term clinical and radiological outcome.** *Neuroradiology* 2002;44:950–954
20. Cortet B, Cotten A, Boutry N, et al. **Percutaneous vertebroplasty in the treatment of osteoporotic vertebral compression fractures: an open prospective study.** *J Rheumatol* 1999;26:2222–2228

ORIGINAL RESEARCH

Vertebroplasty, First 1000 Levels of a Single Center: Evaluation of the Outcomes and Complications

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BACKGROUND AND PURPOSE: Percutaneous polymethylmethacrylate (PMMA) vertebroplasty has become a common procedure for treatment of pain and disability associated with vertebral compression fractures. We reviewed the experience with our first 1000 consecutively treated vertebral compression fractures in an attempt to demonstrate both the short- and long-term safety and efficacy of percutaneous vertebroplasty.

MATERIALS AND METHODS: The first 1000 compression fractures treated by vertebroplasty at our institution were identified from a comprehensive prospectively acquired vertebroplasty data base. All patients treated with vertebroplasty were included, regardless of the underlying pathologic cause. Chart reviews of the procedure notes, imaging studies, clinical visits, and follow-up telephone interviews were performed for each patient. Evaluation at each follow-up time point included pain response (subjective and visual analog pain score), change in mobility, change in pain medication usage, and modified Roland-Morris Disability Questionnaire. Statistical analysis was performed on the pain response and change in the Roland-Morris score at each follow-up time point. Significant procedure-related complications that occurred from the time of the procedure were also specifically extracted from the patients' charts.

RESULTS: There was a dramatic improvement in all the evaluated parameters following percutaneous vertebroplasty. The improvement in pain, mobility, medication usage, and Roland-Morris score was noticed immediately after the procedure and persisted through the 2-year follow-up. There was a low rate of complications from the procedure, the most common being rib fractures.

CONCLUSION: According to our results, practitioners can quote a high success rate and low complication rate for vertebroplasty when making treatment recommendations for painful spinal compression fractures.

Vertebral compression fractures are a common cause of pain and disability.[1-5] There are many causes of vertebral compression fracture, including osteoporosis, trauma, and neoplasm. Osteoporosis among postmenopausal women and patients on long-term steroid therapy are the most frequent causes.[6-8] Percutaneous polymethylmethacrylate (PMMA) vertebroplasty was introduced in the United States approximately 10 years ago, and since that time, it has become the standard of care for treatment of medically refractory vertebral compression fractures.[9]

Conservative management of compression fractures has traditionally included analgesics, braces, immobilization, and physical therapy.[10-14] In its infancy, vertebroplasty was often deferred in favor of medical management to spare patients from a potentially risky procedure. However, bed rest and heavy narcotic usage carry a significant set of risks that are potentially avoided with early treatment, and practitioners are performing the procedure earlier as they become more experienced.

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The literature contains many small case series on the effectiveness of percutaneous vertebroplasty.[15-20] Most of these reports are confined to the treatment of osteoporotic compression fractures and contain a limited evaluation of follow-up results. We provide a comprehensive review of the experience with vertebroplasty at a large academic center and evaluate multiple outcome measures over both short- and long-term follow-up periods.

Materials and Methods

Patient Population

There were 552 patients treated between February 1999 and October 2005. These 552 patients underwent 673 sessions to treat 1000 spinal compression fractures. Sixty-three percent of the treatment sessions (425/673) involved treatment of a single level, whereas 27% (180/673) involved 2 levels, 9% (58/673) involved 3 levels, and 1% (9/673) involved 4 levels. A single case involved treatment of 5 levels, but there were no cases in which treatment of more than 5 fractures was performed in a single session. The average age of patients in our study was 74 years (SD, 10.8 years) with a range of 28–96 years. As expected, a significant percentage of the patients were women. Sixty-nine percent (379/552) were women, whereas 31% (173/552) were men.

Selection Criteria

Institutional review board approval was granted for this study. Vertebroplasty was offered to patients with imaging evidence of an acute or subacute compression fracture of the thoracolumbar spine. Patients with all causes of compression fracture were included in the study. Exclusion criteria for vertebroplasty typically included response to medical management, noncorrelating pain, systemic or spi-

nal infections, and technical factors such as gracile pedicles or vertebra plana. Patients with other causes for pain such as disk herniation, spinal stenosis, or foraminal narrowing were also excluded unless a coexistent compression fracture was thought to contribute significantly to their symptoms. Although most patients were treated initially with conservative medical management, inpatients with intractable pain were offered the procedure earlier than those with pain of less severity. Even patients with prolonged symptoms occurring for many months were offered vertebroplasty if they had correlating pain with evidence of an unhealed fracture. An unhealed fracture was diagnosed if there was persistent edema on MR imaging or corresponding radiopharmaceutical uptake on bone scintigraphy studies. Rarely, patients without vertebral edema on MR imaging or radiopharmaceutical uptake were considered to have an unhealed fracture if there was focal pain with palpation at fluoroscopy corresponding to a known vertebral compression fracture. The average duration of symptoms before treatment was 3.6 months.

Vertebroplasty Procedure

All vertebroplasty procedures were performed by neuroradiologists with expertise in spinal interventions. A preprocedure consultation was performed by a neuroradiologist usually within a few days of the procedure, and this consultation included a focused physical examination with fluoroscopic confirmation of correlating pain. Depending on the patient's underlying medical condition, procedures were performed with the patient under conscious sedation, deep sedation, or general anesthesia. Conscious sedation consisted of intravenous fentanyl and midazolam and was usually begun before placing the patient prone on the fluoroscopy table. Biplane fluoroscopy was used in all cases. After placing the patient prone on the table, we confirmed the fractured level with previously obtained imaging studies and the level to be treated was localized by counting from above and below. Local anesthetic consisted of subcutaneous 1% lidocaine and 0.25% bupivacaine into the deep soft tissues and periosteum with a 22-gauge spinal needle. An 11- or 13-gauge needle with an inner stylet was then advanced under fluoroscopic guidance by using a transpedicular or parapedicular approach into the vertebral body. When the needle was at the junction of the pedicle and body, a biplane digital radiograph was obtained to confirm an appropriate trajectory and exclude a breech of the medial pedicle. The needle was then advanced into the anterior one third of the vertebral body in an attempt to reach the midline. At this point, biplane images were again obtained before PMMA injection. Under a vented hood, a mixture of PMMA, barium, and 1 g of gentamicin was prepared. The cement was injected with an injection device or with 1-mL syringes under biplane fluoroscopic observation until it reached the posterior one fourth of the vertebral body.

The injection was terminated if venous, disk space, or epidural extravasation was encountered. If inadequate filling of the contralateral hemivertebra was noted, a 2nd needle was placed into the contralateral side and additional cement was injected. Patients were instructed to remain supine for 2 hours after the procedure to allow for cement hardening and resolution of sedation. After 2 hours of bed rest, they were evaluated at the bedside and were allowed to ambulate. Outpatients were then discharged, whereas inpatients were allowed to ambulate as tolerated. Up to 5 levels were treated at a single session in the early days of our practice. However, we now typically bring patients back for a 2nd procedure if more than 3 fractures need treatment.

Outcome Measures

At the time of the preprocedure consultation, patient mobility, pain medication usage, visual analog pain scale (0–10) at rest and with activity, and a modified Roland-Morris Disability Questionnaire score were obtained by trained vertebroplasty nurses and neuroradiologists. The Roland-Morris scale was routinely instituted in our practice halfway through the study period because of its specificity in evaluating patients with compression fractures.[21] The visual analog scale was answered in the standard fashion, with 0 being no pain and 10 being the worst pain ever experienced. Preprocedure pain medication type (narcotic versus nonnarcotic), frequency, and route (oral versus intravenous) were recorded. Two hours after vertebroplasty, patients were examined and a visual analog pain score was obtained at rest and with activity. Follow-up telephone interviews were conducted by vertebroplasty nurses at 1 week and 1, 6, 12, and 24 months postprocedure. The inability to contact a patient for 1 time point did not preclude contact at later follow-up time points. Data recorded from the follow-up telephone interviews included subjective and visual analog pain scores at rest and with activity, Roland-Morris score, changes in medication use and mobility, and any complications or new fractures that were encountered.

Statistical Analysis

Statistical analysis was applied to the visual analog pain scores at rest and with activity as well as to the Roland-Morris score response. A nonpaired 2-tailed *t* test was applied to each follow-up time point to assess the significance of pain response and improvement in the Roland-Morris score.

Results

General Patient Characteristics

In the course of our study, 1000 thoracolumbar vertebral compression fractures were treated during 673 procedures in 552 patients. The average cement volume injected was 3.3 mL per level. Conscious sedation was used in 85% (574/673) of patients, with general anesthesia in 12% (79/673) and deep sedation in 3% (20/673). Most of the patients who underwent general anesthesia did so early in the course of the study (Fig 1). As we became more experienced with the procedure, patients were more likely to be treated under conscious sedation. There was a slight decrease in the number of procedures performed during the last year of the study. This is explained, in part, by the inclusion of only 10 months of data during 2005. Additionally, we have recently noticed a small decrease in our vertebroplasty volumes as the procedure is increasingly performed at more institutions. Patients who were referred to our institution early in the course of our study are now more often treated locally as experience with the procedure expands.

Eighty-four percent (562/673) of procedures were performed for compression fractures related to osteoporosis. Compression fractures related to neoplastic involvement were the next most common and accounted for 11% (74/673) of procedures. The remaining 5% (37/673) of patients had fractures caused by hemangiomas or trauma. Although osteoporosis was the most common cause of vertebral compression fracture in both sexes, neoplastic fractures were a more common cause in men (17%) compared with women (8%). Similar to previously reported case series, vertebral compression fractures occurred more commonly at the thoracolumbar

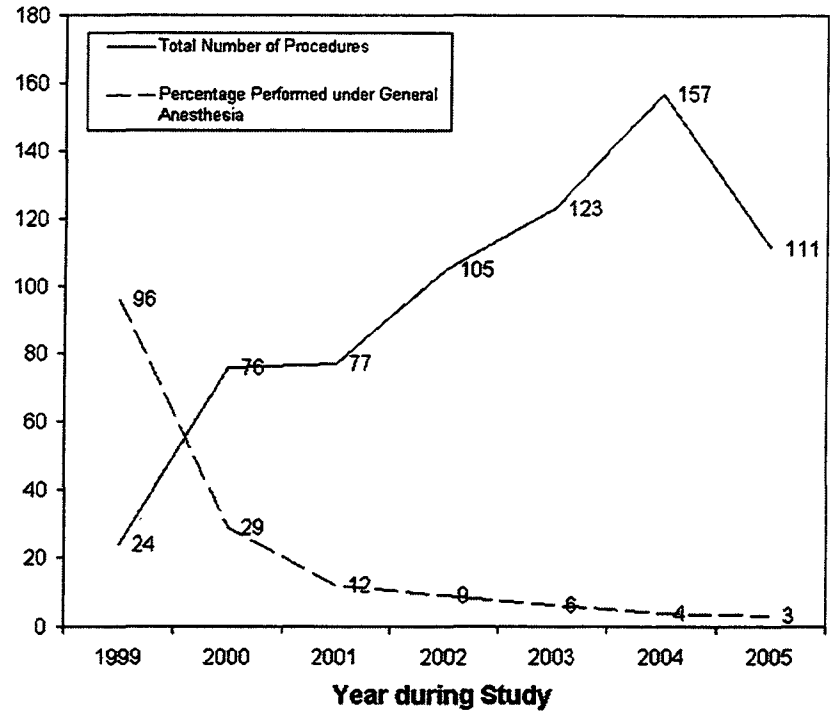

Fig 1. Number of procedures performed with the patient under general anesthesia with time

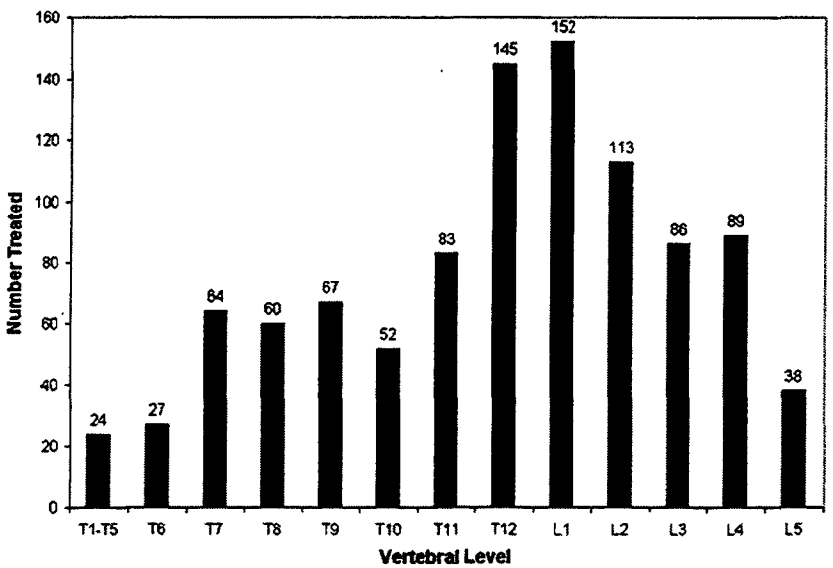

Fig 2. Distribution of treated compression fractures

junction, with T12, L1, and L2 accounting for 41% of treated levels (Fig 2).[22] To obtain a tissue diagnosis for a vertebral compression fracture, we performed a percutaneous biopsy in 9% (61/673) of patients before injection of PMMA. Seventy-nine percent (534/673) of patients underwent vertebroplasty as an outpatient procedure, and 21% (139/673) of procedures were performed on inpatients.

Twenty-three percent of the procedures (156/673) were followed by a new compression fracture or fractures, whereas 77% (517/673) did not develop a new fracture. Of the 156 new fractures, 106 (68%) underwent another vertebroplasty procedure.

Outcome Measures

Compared with the preprocedure visual analog pain score, a significant decrease in pain was seen at rest and with activity. The pain response was apparent at the 2-hour postprocedure evaluation and persisted for every follow-up time point up to 2 years (Fig 3). Similarly, there was a significant improvement in the Roland-Morris score that was apparent at the 1-week follow-up, and this was sustained throughout the 2-year follow-up period (Fig 4). Of significance, the decrease in visual analog pain score and the Roland-Morris score was highly statistically significant at every follow-up time point, with a P value of $<.001$. In our patient population, we had a relatively high rate of follow-up. We were able to obtain follow-up assessments in 89%, 84%, 75%, 67%, and 62% of patients at 1 week and 1, 6, 12, and 24 months, respectively. Most patients also reported an improvement in their mobility, a decrease in pain medication usage, and a qualitative decrease or complete resolution of their pain throughout the 2 years of follow-up (Table). Occasionally, patients reported no change in their

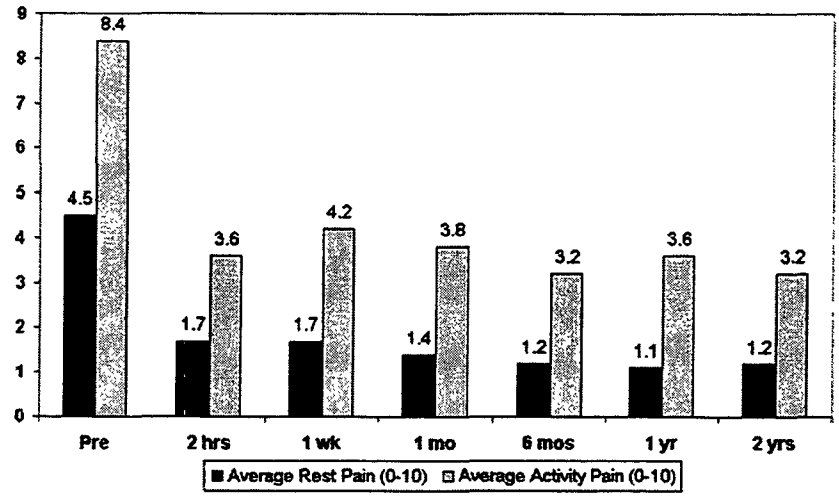

Fig 3. Pain relief following vertebroplasty by using the visual analog pain scale

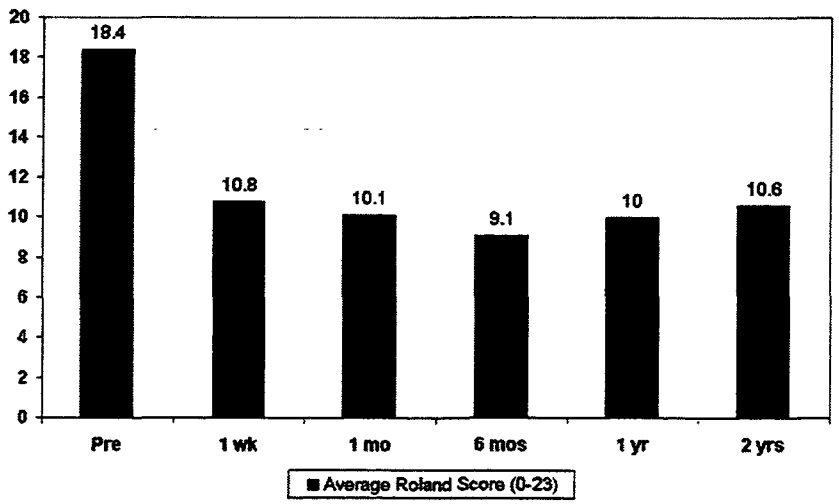

Fig 4. Comparison of the average Roland-Morris score before and after vertebroplasty.

Percentage of patients with improvement in mobility, pain medication usage, and subjective pain after vertebroplasty

	1 week	1 month	6 months	1 year	2 years
Mobility	76%	77%	78%	79%	76%
Medication usage	66%	69%	75%	79%	78%
Pain at rest	87%	87%	88%	87%	91%
Pain with activity	87%	85%	87%	82%	87%

pain at the initial 2-hour follow-up examination. We specifically evaluated this subset of patients to determine what their pain response was at later follow-up time points. Despite reporting no pain relief or worsening of pain at the 2-hour follow-up, most of these patients did get eventual pain relief as demonstrated by a similar decrease in visual analog pain scale at the 1-week through 2-year follow-up time points when compared with that of the entire patient population (Fig 5).

Complications

Clinically significant complications were encountered in only 12 patients (1.8%). Rib fractures related to lying prone on the fluoroscopy table for the vertebroplasty procedure were the most common complication encountered and occurred in 7 patients (1%). Any patient with focal chest wall pain that occurred after the procedure and was clinically referable to the ribs was considered to have a fracture, even if rib radiographs could not confirm a definite fracture. Therefore, it is possible that some of the rib fracture complications recorded could have been related to muscle pain rather than an actual fracture. A single patient was noted to have a transverse process fracture on the side of vertebroplasty needle placement that resulted in 2 weeks of paraspinal pain.

One patient had a clinically significant cement pulmonary embolus. This small embolus was immediately recognized because it occurred during the cement injection, resulting in termination of further cement injection. The patient reported pleuritic chest pain after the procedure and became dyspneic. Although a chest CT did reveal a cement pulmonary embolus, there were no long-term sequelae and the patient made a full recovery.

Five patients had new-onset radiculopathy in our study. However, 3 of these incidents were transient and without a radiographically identifiable cause, and only 2 clinically significant radiculopathy complications were encountered. In these 2 patients, the radiculopathy persisted for several months, and there was radiographic evidence for cement in or very near the neural foramen at the treated level.

A single patient had central spinal canal compromise in a neoplastic fracture. The posterior cortex of the vertebral body was disrupted on a preprocedure CT scan. Although cement

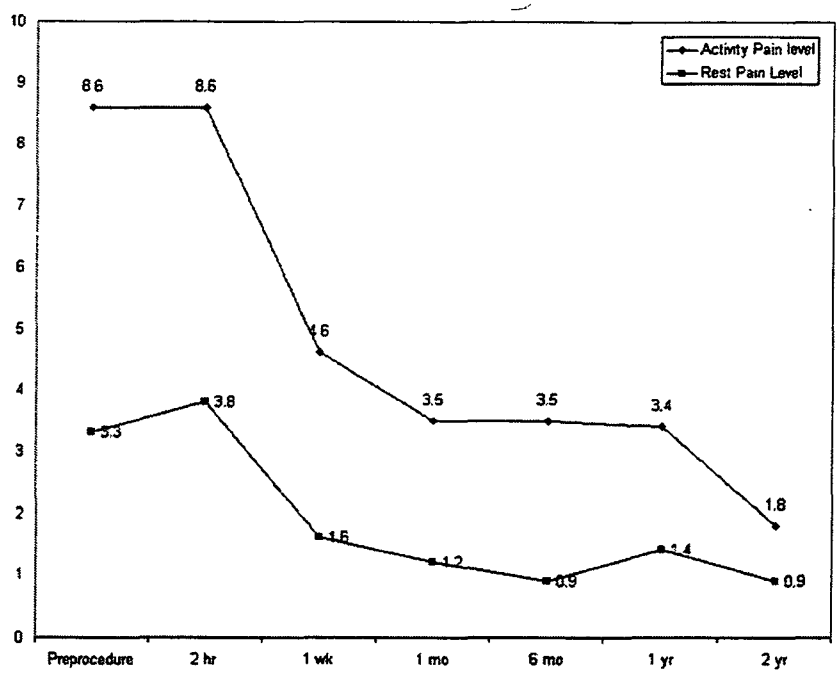

Fig 5. Visual analog pain score changes in the subset of patients who did not experience any pain relief at the 2-hour postprocedure evaluation. Despite no pain relief at 2 hours, these patients experienced significant pain relief at the remaining follow-up time points up to 2 years.

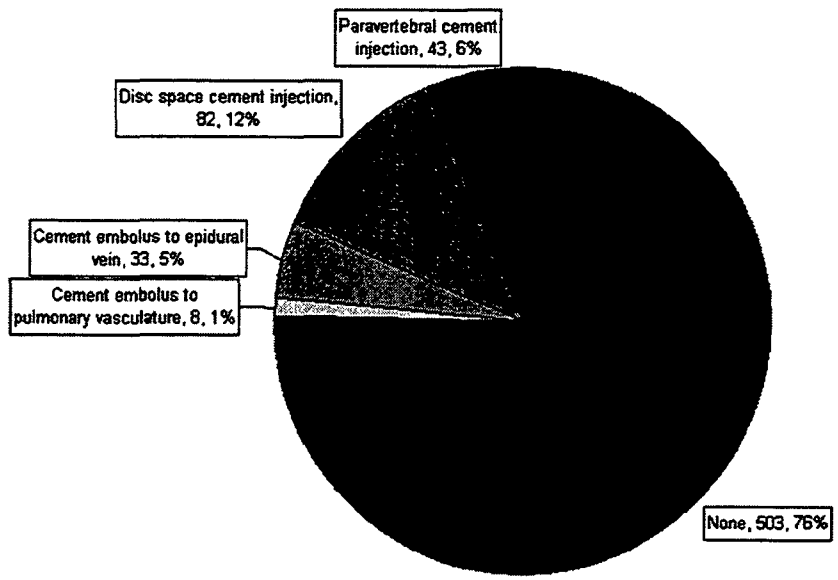

Fig 6. Distribution of cases with cement leakage outside the vertebral body.

was cautiously placed in the vertebral body and no extravertebral leakage was observed, the patient became symptomatic after the procedure, with evidence for neural compression. A postprocedure CT demonstrated interval posterior displacement of tumor into the canal, which required surgical decompression.

Of significance, no infectious complications were encountered in our study population, and no deaths were attributable to the vertebroplasty procedure.

Although we do not consider minimal asymptomatic extravertebral cement extravasation to be a complication of vertebroplasty, any aberrant cement placement during the procedures was recorded. Cement leakage into paravertebral veins, epidural veins, intervertebral disk space, and pulmonary vasculature was encountered in 170 patients (25%). There were 8 patients with cement leakage, with migration of a small amount of cement to the pulmonary vasculature. However, only 1 of these patients (discussed previously) became symptomatic. In the remaining 7 patients, there was no change in pulse oximetry readings or clinical status. This was likely due to the immediate recognition of cement extravasation and termination of injection. In 503 procedures (76%), no aberrant cement placement was encountered (Fig 6).

Discussion

Our study addressed both the short- and long-term outcomes for patients treated with vertebroplasty for vertebral compression fractures of all causes. In our study, most of the patients undergoing vertebroplasty were women, and the most common cause for vertebral compression fracture was osteoporosis. We found an immediate improvement in the degree of pain after vertebroplasty that was present even at the 2-hour postprocedure follow-up evaluation. This improvement in pain continued for all follow-up time-points up to 2 years and

was accompanied by a similar improvement in spine-related disability, mobility, and pain medication usage.

There was a low complication rate in our study, and no procedure-related infection or death was encountered. All of the complications that we encountered have been described in previous vertebroplasty case reports.[9,23,24] Rib fractures occurring at the time of vertebroplasty accounted for most of our complications and are not surprising given that the patients who undergo vertebroplasty procedures are predisposed to rib fractures. In fact, many patients who were treated with vertebroplasty were noted to have rib fractures from minor trauma present before the procedure. We began performing percutaneous vertebroplasty in 1999, and much of our early experience was gained at a time when vertebroplasty literature was sparse and techniques were still evolving. Because we included the procedures at the beginning of our experience, the complication rate for vertebroplasty would be expected to decrease even further because of the experience we have gained with our first 1000 levels.

To our knowledge, this is the largest reported comprehensive series on the outcomes related to percutaneous vertebroplasty. Previous articles on vertebroplasty outcomes have focused on specific etiologies such as osteoporosis or neoplasm. We reported on our experience with vertebroplasty in all patients, regardless of the underlying pathologic process. Patients in our study were followed up at specific intervals that included both short-term 2-hour evaluation and long-term 2-year follow-up interviews. This consistent extended follow-up allowed us to document both the short- and long-term outcomes associated with vertebroplasty and a sustained response to treatment. In an attempt to accurately document the complication rate of vertebroplasty, we performed a thorough chart review. Besides evaluating the radiology reports and radiology department follow-ups, we also reviewed all clinical follow-up visits with all clinical care providers in our institution. This was easily performed because of a systematic electronic medical record at our institution that includes all follow-up contacts, either in person or by telephone. Such a rigorous follow-up is needed to document completely all potential complications.

There are numerous outcome measures recorded in the vertebroplasty literature that attempt to validate this procedure in the treatment of vertebral compression fractures. However, there is significant variability in the outcome measures used to assess the viability of vertebroplasty. The most commonly reported measure is the visual analog pain score, which does provide important information to practitioners. However, relying on pain alone as an outcome measure fails to assess completely the adequacy or inadequacy of vertebroplasty for treating compression fractures. In a report by Trout et al, [21] the importance of a comprehensive tool for spine-related disability, the Roland-Morris Disability Questionnaire, was documented. Any assessment of vertebroplasty should include an analysis of spine-specific measures of pain and disability. Our study incorporated the Roland-Morris Disability Questionnaire and an assessment of mobility and pain medication usage in a large number of patients.

Reported complication rates from percutaneous vertebroplasty have been low.[9,17,25,26] Even with an extensive review of the patients' charts in our study, we report a clinically significant complication rate of only 1%–2%. The low complication rate in our series is likely related to the expertise and subspecialization of the operators. All of the procedures included in our study were performed by neuroradiologists with a specific interest in spine intervention. Epidural, paraspinal, intradiskal, and venous cement extravasation rates for percutaneous vertebroplasty are relatively high and have been documented to occur in up to 88% of patients.[27-30] In our study, 25% (170/673) of patients had some form of cement leakage documented. The documented cases of cement leakage in our study were based on fluoroscopically visualized cement outside the vertebral body at the time of the procedure. Our patients do not routinely undergo CT evaluation afterward, but this percentage would likely be higher if CT were performed to detect smaller areas of cement extravasation. On the basis of our and others' results, it is apparent that small amounts of cement leakage alone should not be considered a complication of vertebroplasty. It is important to recognize cement leakage during the procedure so that it can be terminated or the contralateral pedicle entered, but cement leakage should be considered a stopping point for injection rather than a complication. Despite a cement leakage rate of at least 25% in our series, the clinically significant complications related to cement leakage occurred in only 3 patients (0.45%) and included 2 patients with radiculopathy and a single cement pulmonary embolus. Therefore, claims that kyphoplasty is safer than vertebroplasty because of a decreased rate of cement leakage are unfounded.[31,32]

Our study has several limitations. Although we report on a large patient population with consistent outcome measures, our study is a retrospective review of a prospectively acquired data base. As with most studies on vertebroplasty, there is a potential for bias when patients are evaluated at follow-up. It is possible that the nurse or physician administering the follow-up questions could unintentionally influence the responses that patients gave, depending on how the questions were asked. Because many of the patients were older and resided in nursing homes, it is possible that responses to the follow-up questions were occasionally provided by family members or healthcare providers who interacted with the patients on a daily basis. In those cases in which the patient was unable to give responses to the follow-up questions because of disability or dementia, the responses recorded on follow-up from a surrogate interviewee may not accurately reflect the response intended by the patient. Although we did include responses from surrogate interviewees during follow-up interviews, these responses were limited to a basic assessment of pain, mobility, and medication usage. Surrogate responses were not recorded for the quantitative visual analog pain scores or Roland-Morris Disability Questionnaire.

Although vertebroplasty is considered to be the treatment of choice for painful vertebral compression fractures by many physicians, it has yet to be validated by a prospective randomized study. There are randomized prospective studies currently underway in the United States and internationally, such as the Investigational Vertebroplasty Efficacy and Safety Trial (INVEST), that will address this shortfall in the current vertebroplasty research.[33] It is only after the results of these studies are available that we can unequivocally state that vertebro-

plasty has been validated as a treatment option for patients with painful compression fractures.

Conclusion

On the basis of our results, percutaneous PMMA vertebroplasty is a safe and effective method to treat vertebral compression fractures. An immediate improvement in pain can be expected for most patients, and disability, mobility, and pain medication use are improved during the short- and long-term periods. The complication rate of vertebroplasty is low, with rib fractures being the most common clinically significant complication.

References

1. Hodgson SF, Watts NB, Bilezikian JP, et al. **American Association of Clinical Endocrinologists 2001 medical guidelines for clinical practice for the prevention and management of postmenopausal osteoporosis.** *Endocr Pract* 2001;7:293–312
2. Silverman SL. **The clinical consequences of vertebral compression fracture.** *Bone* 1992;13(suppl 2):S27–31
3. Jackson SA, Tenenhouse A, Robertson L. **Vertebral fractures definition from population-based data: preliminary results from the Canadian Multicenter Osteoporosis Study (CaMos).** *Osteoporos Int* 2000;11:680–87
4. Papaioannou A, Watts NB, Kendler DL, et al. **Diagnosis and management of vertebral fractures in elderly adults.** *Am J Med* 2002;113:220–28
5. Cooper C, Atkinson EJ, Jacobsen SJ, et al. **Population-based study of survival after osteoporotic fractures.** *Am J Epidemiol* 1993;137:1001–05
6. Lindsay R, Silverman SL, Cooper C, et al. **Risk of new vertebral fracture in the year following a fracture.** *JAMA* 2001;285:319–23
7. [No authors listed] **Osteoporosis prevention, diagnosis, and therapy.** *NIH Consensus Statement* 2000;17:1–45
8. van Staa TP, Leufkens HGM, Abenhaim L, et al. **Use of oral corticosteroids and risk of fractures.** *J Bone Miner Res* 2000;15:993–1000
9. Jensen ME, Evans AJ, Mathis JM, et al. **Percutaneous polymethylmethacrylate vertebroplasty in the treatment of osteoporotic vertebral body compression fracture: technical aspects.** *AJNR Am J Neuroradiol* 1997;18:1897–904
10. Lukert BP. **Vertebral compression fractures: how to manage pain, avoid disability.** *Geriatrics* 1994;49:22–26
11. Lyles KW. **Management of patients with vertebral compression fractures.** *Pharmacotherapy* 1999;19(1 Pt 2):21S–24S
12. Wu SS, Lachmann E, Nagler W. **Current medical, rehabilitation, and surgical management of vertebral compression fractures.** *J Womens Health (Larchmt)* 2003;12:17–26
13. Tezer M, Erturer RE, Ozturk C, et al. **Conservative treatment of fractures of the thoracolumbar spine.** *Int Orthop* 2005;29:78–82
14. Old JL, Calvert M. **Vertebral compression fractures in the elderly.** *Am Fam Physician* 2004;69:111–16
15. Prather H, Van Dillen L, Metzler JP, et al. **Prospective measurement of function and pain in patients with non-neoplastic compression fractures treated with vertebroplasty.** *J Bone Joint Surg Am* 2006;88:334–41
16. Singh AK, Pilgram TK, Gilula LA. **Osteoporotic compression fractures: outcomes after single-versus multiple-level percutaneous vertebroplasty.** *Radiology* 2006;238:211–20
17. Anselmetti GC, Corgnier A, Debernardi F, et al. **Treatment of painful compression vertebral fractures with vertebroplasty: results and complications** [in English, Italian]. *Radiol Med (Torino)* 2005;110:262–72
18. Do HM, Kim BS, Marcellus ML, et al. **Prospective analysis of clinical outcomes after percutaneous vertebroplasty for painful osteoporotic vertebral body fractures.** *AJNR Am J Neuroradiol* 2005;26:1623–28
19. Liliang PC, Su TM, Liang CL, et al. **Percutaneous vertebroplasty improves pain and physical functioning in elderly osteoporotic vertebral compression fracture patients.** *Gerontology* 2005;51:34–39
20. Legroux-Gerot I, Lormeau C, Boutry N, et al. **Long-term follow-up of vertebral osteoporotic fractures treated by percutaneous vertebroplasty.** *Clin Rheumatol* 2004;23:310–17
21. Trout AT, Kallmes DF, Gray LA, et al. **Evaluation of vertebroplasty with a validated outcome measure: the Roland-Morris Disability Questionnaire.** *AJNR Am J Neuroradiol* 2005;26:2652–57
22. Evans AJ, Jensen ME, Kip KE, et al. **Vertebral compression fractures: pain reduction and improvement in functional mobility after percutaneous polymethylmethacrylate vertebroplasty retrospective report of 245 cases.** *Radiology* 2003;226:366–72
23. Choe du H, Marom EM, Ahrar K, et al. **Pulmonary embolism of polymethyl methacrylate during percutaneous vertebroplasty and kyphoplasty.** *AJR Am J Roentgenol* 2004;183:1097–102
24. Ratliff J, Nguyen J, Heiss J. **Root and spinal cord compression from methylmethacrylate vertebroplasty.** *Spine* 2001;26:E300–02
25. Hochmuth K, Proschek D, Schwarz W, et al. **Percutaneous vertebroplasty in the therapy of osteoporotic vertebral compression fractures: a critical review.** *Eur Radiol* 2006;16:998–1004
26. Moreland DB, Landi MK, Grand W. **Vertebroplasty: techniques to avoid complications.** *Spine J* 2001;1:66–71
27. Ramos L, de Las Heras JA, Sanchez S, et al. **Medium-term results of percutaneous vertebroplasty in multiple myeloma.** *Eur J Haematol* 2006;77:7–13. Epub 2006 April 11
28. Barragan-Campos HM, Vallee JN, Lo D, et al. **Percutaneous vertebroplasty for spinal metastases: complications.** *Radiology* 2006;238:354–62
29. Krauss M, Hirschfelder H, Tomandl B, et al. **Kyphosis reduction and the rate of cement leaks after vertebroplasty of intravertebral clefts.** *Eur Radiol* 2006;16:1015–21
30. Mousavi P, Roth S, Finkelstein J, et al. **Volumetric quantification of cement leakage following percutaneous vertebroplasty in metastatic and osteoporotic vertebrae.** *J Neurosurg* 2003;99(suppl 1):56–59
31. Coumans JV, Reinhardt MK, Lieberman IH. **Kyphoplasty for vertebral compression fractures: 1-year clinical outcomes from a prospective study.** *J Neurosurg* 2003;99(suppl 1):44–50
32. Phillips FM, Todd Wetzel F, Lieberman I, et al. **An in vivo comparison of the potential for extravertebral cement leak after vertebroplasty and kyphoplasty.** *Spine* 2002;27:2173–78
33. Vertebroplasty for the treatment of fractures due to osteoporosis. **NIH clinical trials website.** Available at: http://www.clinicaltrials.gov. Accessed April 19, 2006

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Foot Bone Resection Partial

CPT codes 28120, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus* and 28122, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicated that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

1700

28120
The RUC first considered the compelling evidence presented by the specialty societies to review the work of 28120. The specialty societies indicated that during the Harvard studies, the wrong specialty was surveyed. The original surveys included only orthopaedic surgeons; however, podiatrists are the primary providers. Further, there is a rank order anomaly between 28120 and 28122. Currently, 28122 requires less physician time, but has a higher work RVU. **The RUC agreed that compelling evidence exists to consider revaluation of the work RVU of 28120.**

The specialty societies presented the results of a survey of 52 orthopaedic surgeons and podiatrists. 65% of the survey respondents indicated that patients spend at least one night in the hospital and are seen post-operatively by the physician on the same day of surgery following the procedure. The RUC agreed that the inclusion of one 99231 hospital visit was appropriate. The RUC also agreed with the two 99213 and three 99212 post-operative office visits as indicated by the surveyees. The RUC understands that the first two visits include a splint/bandage change. The physician continues to see the patient once per week until the wound heals and physical therapy

begins. The RUC reviewed the physician time and noted that the pre-service positioning time should be reduced to 10 minutes to more accurately reflect the service. Lastly, the RUC discussed the proposed work RVU and agreed with the survey 25th percentile work RVU of 8.08. The RUC compared this service to several other codes to support the work RVU including, 15100, *Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 9.74, pre-service = 65, intra-service = 60, post-service = 20) and 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47, pre-service = 50, intra-service = 60, post-service = 25). The RUC compared 28120 to 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88) and noted that the codes are similar, but that 28120 requires greater intensity and complexity. The RUC also agreed that the work RVU of 8.08 corrects an existing rank order anomaly with 28122, which has a work RVU of 7.56. **Therefore, the RUC recommends the survey 25th percentile work RVU of 8.08 for CPT code 28120.**

28122

The RUC first considered the compelling evidence presented by the specialty societies to review the work of 28122. The specialty societies indicated that during the Harvard studies, the wrong specialty was surveyed. The original surveys included on orthopaedic surgeons; however, podiatrists are the primary providers. Further, there is a rank order anomaly between 28120 and 28122. Currently, 28120 requires greater physician time, but has a lower work RVU. **The RUC agreed that compelling evidence exists to consider revaluation of the work RVU of 28122.**

The specialty societies presented the results of a survey of 52 orthopaedic surgeons and podiatrists. 67% of the survey respondents indicated that patients spend at least one night in the hospital and are seen post-operatively by the physician on the same day of surgery following the procedure. The RUC agreed that the inclusion of one 99231 hospital visit is appropriate. The RUC also agreed with the two 99213 and two 99212 post-operative office visits as indicated by the surveyees. The RUC reviewed the physician time and noted that the pre-service positioning time should be reduced to 10 minutes to more accurately reflect the service. Lastly, the RUC discussed the proposed work RVU and agreed that there is no compelling evidence to change the work RVU from its current value, which is 7.56. The RUC compared this service to several other codes to support the work RVU including, 33207, *Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 8.00, pre-service = 47.5, intra-service = 60, post-service = 30) and 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88, pre-service = 50, intra-service = 70, post-service = 20). The RUC also agreed that maintaining the current work RVU of 7.56 is appropriate in relation to its recommendation for 28120. **Therefore, the RUC recommends the maintaining the current work RVU of 7.56 for 28120.**

Practice Expense
The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
28120		Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	090	8.08
28122		tarsal or metatarsal bone, except talus or calcaneus	090	7.56 (No change)

1702

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28120 Tracking Number Specialty Society Recommended RVU: **8.08**

Global Period: 090 RUC Recommended RVU: **8.08**

CPT Descriptor: Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old insulin-dependent diabetic female presents with a chronic, trophic ulcer on the posterior aspect of her right heel. A sinus tract leads to the calcaneus, and bone scans are positive for osteomyelitis. She requires resection of the posterior-inferior aspect of the right calcaneus.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Percent of survey respondents who stated they perform the procedure; In the hospital 87% , In the ASC 13%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 16% , Kept overnight (less than 24 hours) 18% , Admitted (more than 24 hours) 67%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 88%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: • Select and order the appropriate antibiotic(s) and confirm timing and administration.

- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Review results of preadmission testing including labs, X-rays, CT scans, bone scan, 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 prone 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
- The leg is prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, two semi-elliptical incisions are made on the posterior aspect of the right heel, encompassing a 1 cm diameter ulcer. The insertion of the Achilles tendon is identified and protected. Using bone rongeurs and bone curettes, a portion of the posterior-inferior aspect of the calcaneus is resected and sent for culture and pathology. The remaining healthy bone is rasped smooth. The wound is inspected and irrigated. The wound is packed open.

Description of Post-Service Work:
Post-service work: in facility

- Application of a 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 is discharged to the orthopaedic floor for overnight observation to monitor wound, anticoagulation

The physician visits the patient on the floor that evening.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- 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
- 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
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order physical 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)	01/2009				
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Robb Mothershed, DPM; Timothy Tillo, DPM				
Specialty(s):	AAOS; AOFAS; APMA				
CPT Code:	28120				
Sample Size:	300	**Resp N:**	52	**Response:** 17.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	13.00	60.00
Survey RVW:	4.00	8.08	**8.89**	10.55	18.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	45.00	**50.00**	75.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**94.00**	99211x **0.00** 12x **3.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28120	**Recommended Physician Work RVU: 8.08**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**94.00**	99211x **0.00** 12x **3.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 21.1 %

TIME ESTIMATES (Median)	CPT Code: 28120	Key Reference CPT Code: 28289	Source of Time RUC Time
Median Pre-Service Time	58.00	30.00	
Median Intra-Service Time	50.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	94.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**280.00**	**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	3.38	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.08
Urgency of medical decision making	3.46	2.77

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.38
Physical effort required	3.08	3.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.54	3.38
Outcome depends on the skill and judgment of physician	3.38	3.38
Estimated risk of malpractice suit with poor outcome	3.85	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.75	3.18
Intra-Service intensity/complexity	3.42	3.18
Post-Service intensity/complexity	3.50	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.*

We believe that codes 28120 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bon (eg, osteomyelitis or bossing); talus or calcaneus* and 28122 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus* need to be considered together because they have similar and overlapping arguments for review, including wrong specialty surveyed and rank order anomaly.

Both were brought forward by the RUC through the 5-Year Review ID workgroup as part of the site-of-service anomaly review. Both codes were then surveyed for the February 2008 RUC meeting but were postponed for review until the April 2008 RUC meeting. At the April RUC meeting, the AAOS, AOFAS, and APMA presented the two codes for RUC review with a recommendation for an increase in value. At the April 2008 RUC meeting the RUC heard the compelling evidence argument by the presenters and voted to accept the compelling evidence and to allow the presenters to recommend an increased value. However, the actual recommended RVW was rejected, after the compelling evidence was accepted, and the tab was sent to facilitation. At facilitation, it was agreed we would postpone final resolution until the RUC had determined a methodology for dealing with so-called "23hr" stay issues. At the October 2008 RUC meeting, the RUC Research subcommittee approved a revised RUC questionnaire and RUC Summary of Recommendation form that surveyed respondents on these questions. As such, we surveyed the codes and bring them forward to the RUC at this meeting for final consideration.

Wrong Specialty Surveyed – 28120

Current data for 28120 (2008 RVW=5.64) is based on a Harvard survey of orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-op visits were predicted by a CMS contractor (Dan Dunn) using an algorithm (not survey). The current RVW (5.64) and Harvard time/visit data result in a low IWPUT = 0.007.

Current Medicare utilization data indicate that podiatry is the primary provider for 28120 (51%) compared with orthopaedic surgery (37%). For the current RUC survey, both orthopaedic surgeons and podiatrists were surveyed. The survey statistics for all surveys and by specialty are presented below, showing that there is a significant difference in the post-operative visits between the specialties.

SPEC	Resp	Median RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
ALL	52	**8.89**	45	10	15	50	20	1	1	1	2	3
ORT	25	**9.00**	40	10	15	45	20	2	1	1	2	2
POD	27	**8.77**	45	10	15	60	20	1	1	1	3	3

Wrong Specialty Surveyed – 28122

Current data for 28122 (2008 RVW=7.56) is based on a Harvard survey of orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-op visits were predicted by a CMS contractor (Dan Dunn) using an algorithm (not survey). The current RVW (7.56) and Harvard time/visit data result in a low IWPUT = 0.033.

Current Medicare utilization data indicate that podiatry is the primary provider for 28122 (74%) compared with orthopaedic surgery (21%). For the current RUC survey, both orthopaedic surgeons and podiatrists were surveyed. The survey statistics for all surveys and by specialty are presented below, showing that there is a significant difference in the post-operative visits between the specialties.

SPEC	Resp	Median RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
ALL	33	**8.35**	45	10	15	45	20	1	1	1	4	2
ORT	10	**8.00**	40	10	15	45	20	2	1	1	2	2
POD	23	**9.00**	45	10	15	60	20	1	1	1	2	4

Rank Order Anomaly – 28120 and 28122

We also note that the Harvard-based RVWs for 28120 (RVW=5.64) and 28122 (RVW=7.56) present a rank order anomaly. Harvard only surveyed for intra-time for these two codes, which showed that 28120 had greater intra-time than 28122 (67 vs 51 min). The prediction of post-work resulted in 28120 having less post-work compared with 28122. This resulted in 28120 having a lower RVW than 28122. We believe this is incorrect and is clearly an indication that use of the prediction algorithm was flawed for these two codes.

We believe there is a rank order anomaly - code 28120 should have a higher RVW than 28122 for the following reasons:

- Code 28120 requires slightly more intra-operative time than 28122. The talus and calcaneus, being the largest bones of the foot, and the most weightbearing, would cause a greater risk of morbidity and subsequent limb loss in the typical diabetic patient with osteomyelitis.

We believe we have compelling evidence to review the survey data and RVWs for 28120 and 28122 based on the arguments above that indicate the wrong specialty was surveyed and the predicted pre/post-work resulted in incorrect assumptions (ie, incorrect rank order).

RATIONALE FOR REVISING WORK RVUs:

We have reviewed the pre-service time components and are recommending from the pre-service package 3 a decrease in pre-service evaluation time from to 33 minutes for both codes. This is consistent with the other foot/ankle codes that are part of the site-of-service review and is the standard for pre-service package 3. The pre-service positioning time has been changed by increasing the pre-service positioning time for pre-service package 3 by 17 minutes for a total of 20 minutes pre-service positioning time. The patient for 28120 will be prone, and 20 minutes positioning for prone patients is the same positioning time used for prone patients in other recent orthopaedic RUC summary of recommendations. This allows us to maintain consistency across all musculoskeletal codes for pre-service positioning for prone patients

28120 Site of Service: Although the Medicare claims data in the RUC database indicate 40% inpatient hospital and 41% outpatient hospital, our expert consensus panel believes these patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing t chart, the surgeon will determine if it is safe to discharge the patient.

28122 Site of Service: The Medicare claims data in the RUC database indicate 25% inpatient hospital and 44% outpatient hospital, and 21% ASC. However, our expert consensus panel believes these patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon will determine if it is safe to discharge the patient.

28120 and key ref 28288: In comparison to key reference code 28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint the intra-operative time and post-operative work for 28120 will be greater. Code 28289 is performed only 2% inpatient compared with 28120 which is performed 40% inpatient. The patient undergoing 28120 has more co-morbidities that will require the procedure to typically be performed in a facility, with close monitoring after the procedure. Total time for 28120 is more than 100 minutes greater than the total time for 28289.

28122 and key ref 28289: In comparison to key reference code 28289 *Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head* the intra-operative time and post-operative work for 28120 will be greater. Code 28288 is performed only 6% inpatient compared with 28122 which is performed 25% inpatient. More patients undergoing 28122 have more co-morbidities than code 28288 patients. Total time for 28122 is significantly greater than the total time for 28288.

We recommend an RVW of 8.08 for 28120 and 7.88 for 28122 and the time and visit information shown below This will correct the rank order anomaly between these two codes and correct the undervaluation of postoperative work predicted by Harvard. As the tables show, the IWPUTs for the recommended values are still very low (.022 for 28120 and .030 for 28122). The last table, showing the recommended RVW in comparison to other similarly valued codes, confirms that the total times for 28120 and 28122 are quite high compared to codes with similar

RVWs. This supports that the values we are recommending are, if anything, lower than they should be, but still in better rank order than if the current values were maintained.

Statistics for 28120:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.007	**5.64**	22	0	25	67	21		1.5	1		3.5
Survey data	-0.027	**8.89**	~~45~~	~~10~~	15	50	20	~~1~~	1	1	2	3
Recommended Data	0.022	**8.08**	33	20	15	50	20	0	1	1	2	3

Statistics for 28122:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.033	**7.56**	18	0	25	51	26		1.5	1		5
Survey data	0.023	**8.13**	~~45~~	~~10~~	15	45	20	~~1~~	1	1	2	2
Recommended Data	0.030	**8.15**	33	10	15	45	20	0	1	1	4	2

Additional Supporting References:

CPT	DESCRIPTOR	08RVW	TOTAL TIME	INTRA TIME
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	**6.24**	179	**45**
67911	Correction of lid retraction	**7.38**	183	**50**
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	**7.83**	185	**45**
67904 MPC	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	**7.83**	185	**45**
49505 MPC	Repair initial inguinal hernia, age 5 years or older; reducible	**7.88**	198	**60**
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	***7.88***	**277**	**45**
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	**8.00**	239	**60**
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	***8.08***	**292**	**50**
29891 MPC	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	**9.47**	227	**60**
50590 MPC	Lithotripsy, extracorporeal shock wave	**9.64**	234	**60**
15100 MPC	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	**9.74**	281	**60**
54522 MPC	Orchiectomy, partial	**10.15**	211	**75**
66984 MPC	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	**10.36**	162	**30**
28299 MPC	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	**11.39**	299	**90**

SERVICES REPORTED WITH MULTIPLE 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) 28120

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Podiatry How often? 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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
3,633 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Medicare claims data

Specialty podiatry Frequency 1868 Percentage 51.41 %

Specialty ortho Frequency 1294 Percentage 35.61 %

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. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28122 Tracking Number Specialty Society Recommended RVU: **7.88**

Global Period: 090 RUC Recommended RVU: **7.56**

CPT Descriptor: Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 year-old insulin-dependent diabetic female presents with a chronic, trophic ulcer on the plantar aspect of her right cuboid. A sinus tract leads to the cuboid, and bone scans are positive for osteomyelitis. She requires resection of the inferior aspect of the right cuboid.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Percent of survey respondents who stated they perform the procedure; In the hospital 83% , In the ASC 17%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 12% , Kept overnight (less than 24 hours) 30% , Admitted (more than 24 hours) 58%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 5%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: • Select and order the appropriate antibiotic(s) and confirm timing and administration.

- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Review results of preadmission testing including labs, X-rays, CT scans, bone scan 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 prone 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
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work:

Under anesthesia, two semi-elliptical incisions are made on the plantar aspect of the cuboid, encompassing a 1 cm diameter ulcer. Using bone rongeurs and bone curettes, a portion of the cuboid is resected and sent for culture and pathology. The remaining healthy bone is rasped smooth. The wound is inspected and irrigated. The wound is packed open.

Description of Post-Service Work:
Post-service work: in facility

- Application of a 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 is discharged to the orthopaedic floor for overnight observation to monitor wound, drains, anticoagulation. The physician visits the patient on the floor that evening.

Discharge day:

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- 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
- 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 physical 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)	01/2009				
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Robb Mothershed, DPM; Timothy Tillo, DPM				
Specialty(s):	AAOS; AOFAS; APMA				
CPT Code:	28122				
Sample Size:	300	**Resp N:**	52	**Response:** 17.3 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**6.00**	15.00	50.00
Survey RVW:	4.00	7.88	**8.35**	10.13	17.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	44.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28122	**Recommended Physician Work RVU: 7.56**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**50.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

's this new/revised procedure considered to be a new technology or service? No

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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)	CPT Code: 28122	Key Reference CPT Code: 28288	Source of Time RUC Time
Median Pre-Service Time	58.00	20.00	
Median Intra-Service Time	50.00	30.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	78.0	99.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**264.00**	**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	3.56	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	2.89
Urgency of medical decision making	3.78	3.11

Technical Skill/Physical Effort (Mean)

Technical skill required	3.33	3.11
Physical effort required	3.00	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.89	2.89
Outcome depends on the skill and judgment of physician	3.78	3.33
Estimated risk of malpractice suit with poor outcome	3.73	3.22

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.89	3.11
Intra-Service intensity/complexity	3.33	2.78
Post-Service intensity/complexity	3.33	2.78

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.*

We believe that codes 28120 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bon (eg, osteomyelitis or bossing); talus or calcaneus* and 28122 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus* need to be considered together because they have similar and overlapping arguments for review, including wrong specialty surveyed and rank order anomaly.

Both were brought forward by the RUC through the 5-Year Review ID workgroup as part of the site-of-service anomaly review. Both codes were then surveyed for the February 2008 RUC meeting but were postponed for review until the April 2008 RUC meeting. At the April RUC meeting, the AAOS, AOFAS, and APMA presented the two codes for RUC review with a recommendation for an increase in value. At the April 2008 RUC meeting the RUC heard the compelling evidence argument by the presenters and voted to accept the compelling evidence and to allow the presenters to recommend an increased value. However, the actual recommended RVW was rejected, after the compelling evidence was accepted, and the tab was sent to facilitation. At facilitation, it was agreed we would postpone final resolution until the RUC had determined a methodology for dealing with so-called "23hr" stay issues. At the October 2008 RUC meeting, the RUC Research subcommittee approved a revised RUC questionnaire and RUC Summary of Recommendation form that surveyed respondents on these questions. As such, we surveyed the codes and bring them forward to the RUC at this meeting for final consideration.

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We also note that the Harvard-based RVWs for 28120 (RVW=5.64) and 28122 (RVW=7.56) present a rank order anomaly. Harvard only surveyed for intra-time for these two codes, which showed that 28120 had greater intra-time than 28122 (67 vs 51 min). The prediction of post-work resulted in 28120 having less post-work compared with 28122. This resulted in 28120 having a lower RVW than 28122. We believe this is incorrect and is clearly an indication that use of the prediction algorithm was flawed for these two codes.

We believe there is a rank order anomaly - code 28120 should have a higher RVW than 28122 for the following reasons:

- Code 28120 requires slightly more intra-operative time than 28122. The talus and calcaneus, being the largest bones of the foot, and the most weightbearing, would cause a greater risk of morbidity and subsequent limb loss in the typical diabetic patient with osteomyelitis.

We believe we have compelling evidence to review the survey data and RVWs for 28120 and 28122 based on the arguments above that indicate the wrong specialty was surveyed and the predicted pre/post-work resulted in incorrect assumptions (ie, incorrect rank order).

RATIONALE FOR REVISING WORK RVUs:

We have reviewed the pre-service time components and are recommending from the pre-service package 3 a decrease in pre-service evaluation time from to 33 minutes for both codes. This is consistent with the other foot/ankle codes that are part of the site-of-service review and is the standard for pre-service package 3. The pre-service positioning time has been changed by increasing the pre-service positioning time for pre-service package 3 by 17 minutes for a total of 20 minutes pre-service positioning time. The patient for 28120 will be prone, and 20 minutes positioning for prone patients is the same positioning time used for prone patients in other recent orthopaedic RUC summary of recommendations. This allows us to maintain consistency across all musculoskeletal codes for pre-service positioning for prone patients

28120 Site of Service: Although the Medicare claims data in the RUC database indicate 40% inpatient hospital and 41% outpatient hospital, our expert consensus panel believes these patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing t' chart, the surgeon will determine if it is safe to discharge the patient.

28122 Site of Service: The Medicare claims data in the RUC database indicate 25% inpatient hospital and 44% outpatient hospital, and 21% ASC. However, our expert consensus panel believes these patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon will determine if it is safe to discharge the patient.

28120 and key ref 28288: In comparison to key reference code 28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint the intra-operative time and post-operative work for 28120 will be greater. Code 28289 is performed only 2% inpatient compared with 28120 which is performed 40% inpatient. The patient undergoing 28120 has more co-morbidities that will require the procedure to typically be performed in a facility, with close monitoring after the procedure. Total time for 28120 is more than 100 minutes greater than the total time for 28289.

28122 and key ref 28289: In comparison to key reference code 28289 *Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head* the intra-operative time and post-operative work for 28120 will be greater. Code 28288 is performed only 6% inpatient compared with 28122 which is performed 25% inpatient. More patients undergoing 28122 have more co-morbidities than code 28288 patients. Total time for 28122 is significantly greater than the total time for 28288.

We recommend an RVW of 8.08 for 28120 and 7.88 for 28122 and the time and visit information shown below This will correct the rank order anomaly between these two codes and correct the undervaluation of postoperative work predicted by Harvard. As the tables show, the IWPUTs for the recommended values are still very low (.022 for 28120 and .030 for 28122). The last table, showing the recommended RVW in comparison to other similarly valued codes, confirms that the total times for 28120 and 28122 are quite high compared to codes with similar

RVWs. This supports that the values we are recommending are, if anything, lower than they should be, but still in better rank order than if the current values were maintained.

Statistics for 28120:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.007	**5.64**	22	0	25	67	21		1.5	1		3.5
Survey data	-0.027	**8.89**	~~45~~	~~10~~	15	50	20	~~1~~	1	1	2	3
Recommended Data	0.022	**8.08**	33	20	15	50	20	0	1	1	2	3

Statistics for 28122:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.033	**7.56**	18	0	25	51	26		1.5	1		5
Survey data	0.023	**8.13**	~~45~~	~~10~~	15	45	20	~~1~~	1	1	2	2
Recommended Data	0.030	**8.15**	33	10	15	45	20	0	1	1	4	2

Additional Supporting References:

CPT	DESCRIPTOR	08RVW	TOTAL TIME	INTRA TIME
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	6.24	179	45
67911	Correction of lid retraction	7.38	183	50
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	7.83	185	45
67904 MPC	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	7.83	185	45
49505 MPC	Repair initial inguinal hernia, age 5 years or older; reducible	7.88	198	60
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	*7.88*	277	45
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	8.00	239	60
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	*8.08*	292	50
29891 MPC	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	9.47	227	60
50590 MPC	Lithotripsy, extracorporeal shock wave	9.64	234	60
15100 MPC	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	9.74	281	60
54522 MPC	Orchiectomy, partial	10.15	211	75
66984 MPC	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	10.36	162	30
28299 MPC	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	11.39	299	90

SERVICES REPORTED WITH MULTIPLE 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) 28122

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Podiatry How often? Commonly

Specialty Orthopaedic Surgery How often? Sometimes

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. national frequency not available

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? 10,213 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty podiatry Frequency 7459 Percentage 73.03 %

Specialty ortho Frequency 2263 Percentage 22.15 %

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. The current PLI RVU for 28122 should be maintained as there has been no recommended chang in work RVU.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

	Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings							Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings								Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1		60	0	L037D			4	0		0			-1	1		Yes	9
28120	50	50	1	0	3	2	0	67	-17	L037D	1	0	3.5	0	0	-17	0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0	51	-6	L037D	1	0	5	0	0	-6	0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0	60	30	L037D	1	0	4	0	0	0	0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0	120	-20	L037D	1	0	0	5	0	0	0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0	81	39	L037D	1	0	2.5	0	0	0	0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0	156	-6	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0	182	-2	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0	67.5	2.5	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0	90	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0	60	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
69100	12	8						10	2	L037D						1						No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Foot Arthrodesis

CPT codes 28725, *Arthrodesis; subtalar* and 28730, *Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

1728

28725
The RUC reviewed the specialties' evidence in order to recommend increases in the current work RVU for 28725. The specialties noted that the procedure has never been reviewed by the RUC and that podiatrists, who perform 31% of the procedures were not included in the original Harvard survey. The RUC did not agree that compelling evidence existed to justify an increase in work RVU, but did agree that there was evidence to support a recommendation by the specialties to maintain the current work RVU. The specialty societies presented the results of a survey of 71 orthopaedic surgeons and podiatrists. The survey data showed that 74% of patients stay overnight following the surgery. The specialty also indicated that the typical patient is seen on the same day following the procedure as well as the next day. Because these patients typically have several morbidities, including diabetes, they require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. Therefore, the RUC agreed that one 99231 hospital visit as well as a full 99238 discharge day management service are appropriate. The RUC reviewed the survey data and agreed with the survey median physician times of 70 pre-service, 90 intra-service, and 20 immediate post-service. The RUC was convinced, following a review of the survey data, that that the survey physician time and visit data

accurately the work included in the procedure. Based on its review of the survey data, the RUC agreed that the current work RVU of 11.97 was the appropriate valuation of the work involved in the service. The RUC noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support a work RVU of 11.97 for 28725. Codes 28261, *Capsulotomy, midfoot; with tendon lengthening*, (work RVU = 12.91, pre-service = 60, intra-service = 103, post-service = 30) and 25608, *Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments*, (10.86, pre-service = 65, intra-service = 90, post-service = 30). **The RUC recommends maintaining the current work RVU of 11.97 and accepting the median survey physician time and post-operative visits for CPT code 28725.**

28730

The RUC reviewed the specialties' evidence in order to recommend increases in the current work RVU for 28730. The specialties noted that the procedure has never been reviewed by the RUC and that podiatrists, who perform 33% of the procedures were not included in the original Harvard survey. The RUC did not agree that compelling evidence existed to justify an increase in work RVU, but did agree that there was evidence to support a recommendation by the specialties to maintain the current work RVU. The specialty societies presented the results of a survey of 71 orthopaedic surgeons and podiatrists. The survey data showed that 74% of patients stay overnight following the surgery. The specialty also indicated that the typical patient is seen on the same day following the procedure as well as the next day. Because these patients typically have several morbidities, including diabetes, they require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. Therefore, the RUC agreed that one 99231 hospital visit as well as a full 99238 discharge day management service are appropriate. The RUC survey data and agreed with the survey median physician times of 70 pre-service, 100 intra-service, and 20 immediate post-service. The RUC was convinced, following a review of the survey data, that the survey physician time and visit data accurately the work included in the procedure. Based on its review of the survey data, the RUC agreed that the current work RVU of 12.21 was the appropriate valuation of the work involved in the service. The RUC also noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support a work RVU of 12.21 for 28730. 28309, *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)* (work RVU = 13.96, pre-service = 60, intra-service = 110, post-service = 30) and 29862, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum* (work RVU = 10.97, pre-service = 75, intra-service = 100, post-service = 30). The RUC noted that while the procedures are similar in intensity and complexity, 28730 required less intra-service time than 28309, which accounts for the smaller work RVU. The RUC also commented that 28730 is similar to 29862, which both require 100 minutes of intra-service time, but requires slightly more complexity, which supports the higher work RVU of 28730. **The RUC recommends maintaining the current work RVU of 12.21 and accepting the median survey physician time and post-operative visits for CPT code 28730.**

1729

Practice Expense
The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
28725	Arthrodesis; subtalar	090	11.97 (No Change)
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	090	12.21 (No Change)

1730

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28725 Tracking Number Specialty Society Recommended RVU: **13.50**

Global Period: 090 RUC Recommended RVU: **11.97**

CPT Descriptor: Arthrodesis; subtalar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old male presents with a chronic, painful foot secondary to an old calcaneal fracture. Clinical findings, X-rays and a CT scan reveal an arthritic subtalar joint. He undergoes a subtalar arthrodesis.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Percent of survey respondents who stated they perform the procedure; In the hospital 89% , In the ASC 11%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 17% , Kept overnight (less than 24 hours) 56% , Admitted (more than 24 hours) 27%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 89%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 18%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- 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.
- 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 hindfoot. Neurovascular structures are identified and protected. The incision is carried down through the sinus tarsi to the subtalar joint. The articular cartilage in the subtalar joint is removed down to bleeding bone. Loose fragments are irrigated and removed. The foot is placed in a functional position and the fusion is fixed with internal fixation. Position is verified using fluoroscopy. The wound is inspected and irrigated. Bone graft is inserted as necessary. A hemovac drain is placed. The wound is closed in layers.

Description of Post-Service Work:

Post-service work: in facility

- Application of a dressing and short leg splint.
- Monitor patient during reversal of anesthesia.
- 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.
- Discuss procedure and outcome with family in waiting area.
- Write brief operative note or complete final operative note and place in chart.
- Dictate operative report and copy referring physician(s).
- Correctly assign CPT codes including Physicians Quality and Reporting Initiative (PQRI) add-on codes where appropriate.
- Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Review nursing/other staff patient chart notes.
- The circulation, sensation and motor function of the operated extremity are assessed.
- 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
- 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)	01/2009				
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Robb Mothershed, DPM; Timothy Tillo, DPM				
Specialty(s):	AAOS; AOFAS; APMA				
CPT Code:	28725				
Sample Size:	300	**Resp N:**	71	**Response:** 23.6 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**6.00**	15.00	100.00
Survey RVW:	8.30	13.50	**15.00**	16.00	30.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	35.00	70.00	**90.00**	120.00	300.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**101.00**	99211x **0.00** 12x **2.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28725	**Recommended Physician Work RVU: 11.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**45.00**	**33.00**	**12.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**101.00**	99211x **0.00** 12x **2.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
27870	090	15.21	**RUC Time**

CPT Descriptor Arthrodesis, ankle, 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 45 **% of respondents:** 63.3 %

TIME ESTIMATES (Median)	CPT Code: 28725	Key Reference CPT Code: 27870	Source of Time
Median Pre-Service Time	70.00	60.00	
Median Intra-Service Time	90.00	140.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
edian Office Visit Time	101.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**339.00**	**400.00**	
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	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.56
Urgency of medical decision making	2.43	2.51

Technical Skill/Physical Effort (Mean)

Technical skill required	4.16	4.15
Physical effort required	3.82	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.71	3.85
Outcome depends on the skill and judgment of physician	4.24	4.20
Estimated risk of malpractice suit with poor outcome	3.68	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.64	3.61
Intra-Service intensity/complexity	4.11	4.07
Post-Service intensity/complexity	3.31	3.32

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We believe that codes 28725 Arthrodesis; subtalar and 28730 Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse, need to be considered together because they have similar and overlapping arguments for review, including wrong specialty surveyed. Both were brought forward by the RUC through the 5-Year Review ID workgroup as part of the site-of-service anomaly review. Both codes were then surveyed for the February 2008 RUC meeting but were postponed for review until the April 2008 RUC meeting. At the April RUC meeting, the AAOS, AOFAS, and APMA in a joint letter requested the two codes be postponed further until the RUC had arrived at a methodology for

dealing with procedures where the dominant specialties believed physicians were performing hospital visits and patients were not being discharged within 23 hours even if the hospitals were reporting a same-day discharge. At the October 2008 RUC meeting, the RUC Research subcommittee approved a revised RUC questionnaire and RUC Summary of Recommendation form that surveyed respondents on these questions. As such, we surveyed the codes and bring them forward to the RUC at this meeting for final consideration.

Wrong Specialty Surveyed - 28725

Current data for 28725 (2008 RVW=11.97) is based on a Harvard survey of orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-op visits were predicted by a CMS contractor (Dan Dunn) using an algorithm (not survey).

Current Medicare utilization data indicate that podiatry is a very significant provider for 28725 (31%). For the current RUC survey, both orthopaedic surgeons and podiatrists were surveyed and we believe this is a more thorough and accurate assessment of providers. The survey statistics for all surveys and by specialty are presented below, showing that there is a significant difference in the post-operative visits between the specialties.

SPEC	Resp	Median RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99231	99238	99213	99212
ALL	71	**15.00**	45	10	15	90	20	1	1	3	2
ORT	49	**15.00**	40	10	15	100	20	1	1	3	1
POD	22	**14.35**	60	15	17.5	97	30	1	1	4	2

Wrong Specialty Surveyed - 28730

Current data for 28730 (2008 RVW=12.21) is based on a Harvard survey of orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-op visits were predicted by a CMS contractor (Dan Dunn) using an algorithm (not survey).

Current Medicare utilization data indicate that podiatry is a very significant provider for 28730 (33%). For the current RUC survey, both orthopaedic surgeons and podiatrists were surveyed and we believe this is a more thorough and accurate assessment of providers. The survey statistics for all surveys and by specialty are presented below, showing that there is a significant difference in the post-operative visits between the specialties.

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POD	22	**14.00**	60	15	20	120	30	1	1	4	2

We believe we have compelling evidence to review the survey data and RVWs for 28725 and 28730 based on the arguments above that indicate the wrong specialty was surveyed and the predicted pre/post-work resulted in incorrect assumptions

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RATIONALE FOR REVISING WORK RVUs:

We have reviewed the pre-service time components and are recommending the pre-service package of 3. We are using 33 for pre-service evaluation time This is consistent with the other foot/ankle codes that are part of the site-of-service review and is the standard for pre-service package 3. The pre-service positioning time has been kept at 3 minutes, which is the pre-service positioning time assigned by pre-service standard package 3. Pre-service Scrub, Dress and Wait time is also maintained at 15 minutes.

28725 Site of Service: Although the Medicare claims data in the RUC database indicate 41% inpatient hospital and 49% outpatient hospital, our expert consensus panel believes these patients require close monitoring on the day of

the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon will determine if it is safe to discharge the patient. Our expert panel does not believe a separat hospital visit is typically performed on the day of the procedure.

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28725 and key ref 27870: In comparison to key reference code 28289 Arthrodesis, ankle, open, the intra-operative time for 28725 will be less than 27870 (90 minutes versus 140 minutes) as will post-operative work for 28725 (28725 has a total post-operative visit time of 121 minutes versus a total post-operative visit time of 132 minutes for 27870) Total time for 27870 is 80 minutes more than the total time for 28725 (400 minutes for 27870 and 320 minutes for 28725). The IWPUT for 28725 is appropriately greater than the IWPUT for 27870 (.071 versus .048)

28730 and key ref 27870: In comparison to key reference code 28289 Arthrodesis, ankle, open, the intra-operative time for 28730 will be less than 27870 (100 minutes versus 140 minutes) as will post-operative work for 28730 (28730 has a total post-operative visit time of 121 minutes versus a total post-operative visit time of 132 minutes for 27870). Total time for 27870 is 70 minutes more than the total time for 28730 (400 minutes for 27870 and 330 minutes for 28730). The IWPUT for 28730 is appropriately greater than the IWPUT for 27870 (.069 versus .048)

We recommend an RVW of 13.50 for 28725 and 14.00 for 28730 and the time and visit information shown below. This will correctly value these two procedures relative to key reference code 27870 and other codes in the physician fee schedule

Statistics for 28725:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.064	**11.97**	25	0	25	89	22		2	1	4	0
Survey data	0.083	**15.00**	~~45~~	~~10~~	15	90	20		1	1	3	2
Recommended Data	0.071	**13.50**	33	3	15	90	20		1	1	3	2

Statistics for 28730:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.041	**12.21**	60			140	30		2	1	4	0
Survey data	0.075	**15.00**	~~45~~	~~10~~	15	100	20		1	1	3	2
Recommended Data	0.069	**14.00**	33	3	15	100	20		1	1	3	2

Additional Supporting References:

CPT	DESCRIPTOR	08RVW	TOTAL TIME	INTRA TIME
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	9.09	179	**45**
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of	9.47	227	**60**

	talus and/or tibia, including drilling of the defect			
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	10.86	305	**90**
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	10.97	297	**100**
28114	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	11.61	339	**90**
28261	Capsulotomy, midfoot; with tendon lengthening	12.91	343	**103**
63030 (MPC)	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar (including open or endoscopically-assisted approach)	13.03	342	**90**
28725	**Arthrodesis; subtalar**	**13.50**	**320**	**90**
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	13.96	350	**110**
28730	**Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**	**14.00**	**330**	**100**
36819 (MPC)	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	14.39	257	**120**
24430 (MPC)	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	15.07	343	**102**
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	15.21	395	**120**
27870	Arthrodesis, ankle, open	15.21	400	**140**
27428 (MPC)	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	15.33	363	**120**
28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	17.01	380	**140**

SERVICES REPORTED WITH MULTIPLE 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) 28725

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Commonly

Specialty 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. national, non-medicare, frequency figures not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,557 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2006 Medicare frequency

Specialty orthopaedic surgery Frequency 1746 Percentage 68.28 %

Specialty podiatry Frequency 804 Percentage 31.44 %

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. There is no change in the work RVU, therefore the PLI RVU should remain the same.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:28730 Tracking Number Specialty Society Recommended RVU: **14.00**

Global Period: 090 RUC Recommended RVU: **12.21**

CPT Descriptor: Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents with foot pain secondary to rheumatoid arthritis. X-rays and CT scan reveal severely arthritic tarsometatarsal joints. She requires arthrodesis of the tarsometatarsal joints.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 92% , In the ASC 8%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 15% , Kept overnight (less than 24 hours) 55% , Admitted (more than 24 hours) 29%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 80%

's moderate sedation inherent to this procedure in the Hospital/ASC setting? No
ercent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 21%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: • Select and order the appropriate antibiotic(s) and confirm timing and administration.

- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- 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.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: Under anesthesia, two incisions are made over the medial first and dorsal third tarsometatarsal joints. Neurovascular structures are identified and protected. The incision is carried down to bone and the tarsometatarsal joints are exposed. The articular cartilage is removed down to bleeding bone. Loose fragments are irrigated and removed. The foot is placed in a functional position and the fusion is fixed with internal fixation. Posit is verified using fluoroscopy. The wound is inspected and irrigated. Bone graft is inserted as necessary. A hemc drain is placed. The wound is closed in layers.

Description of Post-Service Work:
Post-service work: in facility

- Application of a dressing and short leg splint.
- Monitor patient during reversal of anesthesia.
- 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.
- Discuss procedure and outcome with family in waiting area.
- Write brief operative note or complete final operative note and place in chart.
- Dictate operative report and copy referring physician(s).
- Correctly assign CPT codes including Physicians Quality and Reporting Initiative (PQRI) add-on codes where appropriate.
- Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.
- Monitor and document patient progress.
- Assess pain scores and adequacy of analgesia.
- Review nursing/other staff patient chart notes.
- The circulation, sensation and motor function of the operated extremity are assessed.
- 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
- 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)	01/2009
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Frank Spinosa, DPM; Robb Mothershed, DPM; Timothy Tillo, DPM
Specialty(s):	AAOS; AOFAS; APMA
CPT Code:	28730
Sample Size: 300	**Resp N:** 71 — **Response:** 23.6 %
Sample Type:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	12.00	35.00
Survey RVW:	9.30	14.00	**15.00**	17.00	25.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	90.00	**100.00**	120.00	280.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**101.00**	99211x **0.00** 12x **2.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	28730	**Recommended Physician Work RVU: 12.21**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**45.00**	**33.00**	**12.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**100.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
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Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27870	090	15.21	RUC Time

CPT Descriptor Arthrodesis, ankle, 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	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 32.3 %

TIME ESTIMATES (Median)	CPT Code: 28730	Key Reference CPT Code: 27870	Source of Time
Median Pre-Service Time	70.00	60.00	
Median Intra-Service Time	100.00	140.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	101.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**349.00**	**400.00**	
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	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.86
Urgency of medical decision making	2.59	3.64

Technical Skill/Physical Effort (Mean)

Technical skill required	4.68	4.32
Physical effort required	3.86	3.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.14	4.00
Outcome depends on the skill and judgment of physician	4.50	4.23
Estimated risk of malpractice suit with poor outcome	3.73	3.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.70	3.68
Intra-Service intensity/complexity	4.57	4.41
Post-Service intensity/complexity	3.52	3.55

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We believe that codes 28725 Arthrodesis; subtalar and 28730 Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse, need to be considered together because they have similar and overlapping arguments for review, including wrong specialty surveyed. Both were brought forward by the RUC through the 5-Year Review ID workgroup as part of the site-of-service anomaly review. Both codes were then surveyed for the February 2008 RUC meeting but were postponed for review until the April 2008 RUC meeting. At the April RUC meeting, the AAOS, AOFAS, and

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RATIONALE FOR REVISING WORK RVUs:

We have reviewed the pre-service time components and are recommending the pre-service package of 3. We are using 33 for pre-service evaluation time This is consistent with the other foot/ankle codes that are part of the site-of-service review and is the standard for pre-service package 3. The pre-service positioning time has been kept at 3 minutes, which is the pre-service positioning time assigned by pre-service standard package 3. Pre-service Scrub, Dress and Wait time is also maintained at 15 minutes.

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28730 Site of Service: The Medicare claims data in the RUC database indicate 38% inpatient hospital and 49% outpatient hospital, and 12% ASC. However, our expert consensus panel believes these patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon will determine if it is safe to discharge the patient. Our expert panel does not believe a separate hospital visit is typically performed on the day of the procedure.

28725 and key ref 27870: In comparison to key reference code 28289 Arthrodesis, ankle, open, the intra-operative time for 28725 will be less than 27870 (90 minutes versus 140 minutes) as will post-operative work for 28725 (28725 has a total post-operative visit time of 121 minutes versus a total post-operative visit time of 132 minutes for 27870) Total time for 27870 is 80 minutes more than the total time for 28725 (400 minutes for 27870 and 320 minutes for 28725). The IWPUT for 28725 is appropriately greater than the IWPUT for 27870 (.071 versus .048)

28730 and key ref 27870: In comparison to key reference code 28289 Arthrodesis, ankle, open, the intra-operative time for 28730 will be less than 27870 (100 minutes versus 140 minutes) as will post-operative work for 28730 (28730 has a total post-operative visit time of 121 minutes versus a total post-operative visit time of 132 minutes for 27870). Total time for 27870 is 70 minutes more than the total time for 28730 (400 minutes for 27870 and 330 minutes for 28730). The IWPUT for 28730 is appropriately greater than the IWPUT for 27870 (.069 versus .048)

We recommend an RVW of 13.50 for 28725 and 14.00 for 28730 and the time and visit information shown below. This will correctly value these two procedures relative to key reference code 27870 and other codes in the physician fee schedule

Statistics for 28725:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.064	**11.97**	25	0	25	89	22		2	1	4	0
Survey data	0.083	**15.00**	~~45~~	~~10~~	15	90	20		1	1	3	2
Recommended Data	0.071	**13.50**	33	3	15	90	20		1	1	3	2

Statistics for 28730:

Source	IWPUT	RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99213	99212
Harvard	0.041	**12.21**	60			140	30		2	1	4	0
Survey data	0.075	**15.00**	~~45~~	~~10~~	15	100	20		1	1	3	2
Recommended Data	0.069	**14.00**	33	3	15	100	20		1	1	3	2

Additional Supporting References:

CPT	DESCRIPTOR	08RVW	TOTAL TIME	INTRA TIME
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	9.09	179	**45**
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	9.47	227	**60**
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	10.86	305	**90**
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	10.97	297	**100**

28114	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	11.61	339	**90**
28261	Capsulotomy, midfoot; with tendon lengthening	12.91	343	**103**
63030 (MPC)	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar (including open or endoscopically-assisted approach)	13.03	342	**90**
28725	**Arthrodesis; subtalar**	**13.50**	**320**	**90**
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	13.96	350	**110**
28730	**Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**	**14.00**	**330**	**100**
36819 (MPC)	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	14.39	257	**120**
24430 (MPC)	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	15.07	343	**102**
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	15.21	395	**120**
27870	Arthrodesis, ankle, open	15.21	400	**140**
27428 (MPC)	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	15.33	363	**120**
28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	17.01	380	**140**

SERVICES REPORTED WITH MULTIPLE 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 unlis code is reviewed) 28730

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? 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. national, non-medicare, frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,499 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2006 Medicare Utilization

Specialty orthopaedic surgery Frequency 996 Percentage 66.44 %

Specialty podiatry Frequency 499 Percentage 33.28 %

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. There is no change in the work RVU, therefore the PLI RVU should remain the same.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings								Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings									Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1		60	0	L037D			4	0		0			-1	1		Yes	9
28120	50	50	1	0	3	2	0	67	-17	L037D	1	0	3.5	0	0	-17	0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0	51	-6	L037D	1	0	5	0	0	-6	0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0	60	30	L037D	1	0	4	0	0	0	0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0	120	-20	L037D	1	0	0	5	0	0	0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0	81	39	L037D	1	0	2.5	0	0	0	0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0	156	-6	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0	182	-2	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0	67.5	2.5	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0	90	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0	60	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
69100	12	8						10	2	L037D						1						No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Interventional Radiology Procedures

In June 2008, CMS requested the RUC to review direct practice expense recommendations in the non-facility setting for the following CPT Codes:

36481 *Percutaneous portal vein catheterization by any method*
37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated*
47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency*
50200 *Renal biopsy; percutaneous, by trocar or needle*

1754

At the October 2008 RUC meeting all of the CMS requested interventional radiology procedures were reviewed for practice expense and recommendations were made to place all of the procedures on CPT's appendix G to indicate that Moderate Sedation is inherent to these procedures. At that time, the RUC tabled code 36481 after determining that the medical supplies and equipment time included in the recommendation overlapped other services, such as imaging services, that are typically billed at the same time. The RUC also determined the specialty society recommendation lacked RUC standards for practice expense and that other similar services recently reviewed by the RUC may require revised recommendations. Codes 75885 *Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation* and 75887 *Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation* were identified as services to be reviewed concurrently with 36481 at the February 2009 RUC meeting.

At the February 2009 RUC meeting the RUC reviewed the practice expense input recommendations for codes 36481, 75885, and 75887 in tandem as to prevent any overlap or double counting of clinical staff, medical supplies, and/or equipment. The RUC made a minor change to a medical supply and agreed with the remainder of the specialty society's recommendations. **The RUC recommends the attached non-facility direct practice expense inputs for CPT codes 36481, 75885, and 75887.**

CPT Code (•New)	CPT Descriptor	Global Period	Recommendation
⊙36481	Percutaneous portal vein catheterization by any method	000	PE Review Only
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	XXX	PE Review Only
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	XXX	PE Review Only

1755

	A	B	C	D	E	F	G	H	I
1				36481		75885		75887	
2	Meeting Date: Jan/Feb 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Percutaneous portal vein catheterization by any method		Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation		Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000
5	TOTAL TIMES BY STAFF TYPE								
6		L037D	RN/LPN/MTA	24.0	13.0	0.0	0.0	0.0	0.0
7		L041A	Angio Tech	84.0	0.0	0.0	0.0	0.0	0.0
8		L051A	RN	142.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL CLINICAL LABOR TIME			250.0	13.0	0.0	0.0	0.0	0.0
10	TOTAL CLINICAL LABOR TIME			253.0	13.0	55.0	0.0	55.0	0.0
11	TOTAL PRE-SERV CLINICAL LABOR TIME			8.0	10.0	6.0	0.0	6.0	0.0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			242.0	0.0	49.0	0.0	49.0	0.0
13	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	3.0	0.0	0.0	0.0	0.0
14	PRE-SERVICE								
15	Start: Following visit when decision for surgery or procedure made								
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5				
17	Coordinate pre-surgery services	L037D	RN/LPN/MTA						
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA	3	5				
19	Provide pre-service education/obtain consent								
20	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA						
21	Other Clinical Activity (please specify) - Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	Angio Tech			6		6	
22	End: When patient enters office/facility for surgery/procedure								
23	SERVICE PERIOD								
24	Start: When patient enters office/facility for surgery/procedure: Services Prior to Proced								
25	Review charts	L037D	RN/LPN/MTA	2					
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	3					
27	Obtain vital signs	L037D	RN/LPN/MTA	5					
28	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3					
29	Prepare room, supplies	L041A	Angio Tech	4					
30	Prepare equipment	L041A	Angio Tech			3		3	
31	Setup scope (non facility setting only)								
32	Prepare and position patient/ monitor patient/ set up IV	L051A	RN	2					
33	Sedate/apply anesthesia	L051A	RN	2					
34	Position patient for imaging	L041A	Angio Tech			3		3	
35	INTRA-SERVICE								
36	Assist physician in performing procedure - CS	L051A	RN	75					
37	Assist physician in performing procedure	L041A	Angio Tech	75					
38	Assist MD with image acquisiton					16		16	
39	Assist MD with fluoroscopy during the procedure	L041A	Angio Tech			19		19	
40	POST-SERVICE								
41	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60					
42	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3					
43	Clean Scope								
44	Clean Surgical Instrument Package								
45	Clean Imaging Equipment	L041A	Angio Tech			3		3	
46	Complete diagnostic forms, lab & X-ray requisitions	L041A	Angio Tech	5					
47	Review/read X-ray, lab, and pathology reports								
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN	3					
49	Discharge day management								
50	Other Clinical Activity (please specify) - post procedure imaging processing	L041A	Angio Tech			5		5	
51	End: Patient leaves office								

	A	B	C	D	E	F	G	H	I
1				36481		75885		75887	
2	Meeting Date: Jan/Feb 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Percutaneous portal vein catheterization by any method		Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation		Percutaneous transhepatic portography without hemodyna evaluation, radio supervision and interpretation	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
52	[redacted]								
53	Start: Patient leaves office/facility								
54	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3				
55	*Office visits: NONE*								
63	*Total Office Visit Time*			0	0	0	0	0	0
64	Other Activity (please specify)								
65	End: with last office visit before end of global period								
66	[redacted]								
67	pack, minimum multi-specialty visit	SA048	pack	1					
68	pack, conscious sedation	SA044	pack	1					
69	kit, IV starter	SA019	kit	1					
70	gown, surgical, sterile	SB028	item	2					
71	gloves, sterile	SB024	pair	3					
72	mask, surgical, with face shield	SB034	item	2					
73	cap, surgical	SB001	item	2					
74	shoe covers, surgical	SB039	pair	2					
75	tray, shave prep	SA067	tray	1					
76	underpad 2ftx3ft (Chux)	SB044	item	1					
77	drape, sterile, femoral	SB009	item	1					
78	drape-towel, sterile 18inx26in	SB019	item	4					
79	Betadine	SJ041	ml	60					
80	applicator, sponge-tipped	SG009	item	4					
81	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10					
82	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2					
83	heparin 1,000 units-ml inj	SH039	ml	5					
84	sodium chloride 0.9% flush syringe	SH065	item	2					
85	closed flush system, angiography	SC010	item	1					
86	catheter, angiographic, pig-tail	SC008	item	1					
87	blade, surgical (Bard-Parker)	SF007	item	1					
88	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1					
89	guidewire, hydrophilic (Glidewire)	SD089	item	1					
90	guidewire, (Bentson)	SD172	item	1					
91	guidewire (Transcend)	SD175	item	1					
92	microcatheter guidewire introducer	SA016	item	1					
93	vascular sheath	SD136	item	1					
94	catheter microcatheter selective	SD154	item	1					
95	catheter (SIM2F1)	SD148	item	1					
96	catheter, curved (Headhunter)	SD153	item	1					
97	catheter (Glide)	SD147	item	1					
98	steri-strip (6 strip uou)	SG074	item	1					
99	sterile bowl	SD171	item	2					
100	gauze, sterile 4in x 4in	SG055	item	2					
101	dressing 3 X 4 wound care telfa	SG035	item	2					
102	tape, surgical paper 1in (Micropore)	SG079	item	6					
103	drape, sterile, c-arm, fluoro	SB008	item	1					
104	Tegaderm dressing	SG037	item	1					
105									
106	biohazard bag	SM004	item	2					
107	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1					
108	drape, sterile, c-arm, fluoro	SD008	item			1		1	
109	x-ray ID card (flashcard)	SK093	item			1		1	
110	film, x-ray 14inx17in	SK034	item			4		4	
111	x-ray envelope	SK091	item			1		1	
112	disinfectant, surface (Envirocide, Sanizide)	SM013	oz			1		1	
113	computer media, dvd	SK013	item			1		1	
114	[redacted]								
115	room, angiography	EL011	1	X		9 minutes		9 minutes	
116	pulse oximeter w-printer	EQ211	1	X					
117	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011	1	X					
118	IV infusion pump	EQ032	1			X		X	
119	stretcher	EF018	1	X					
120	film alternator	ED024	1			X		X	
121	film printer laser	ED032	1			X		X	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2008 - CMS Request: Practice Expense Review

Interventional Radiology Procedures

In June 2008, CMS requested the RUC to make a direct practice expense recommendation for the non-facility setting for the following CPT Codes:

36481 *Percutaneous portal vein catheterization by any method*
37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated*
47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency*
50200 *Renal biopsy; percutaneous, by trocar or needle*

1758

The RUC initiated a level of interest process in June 2008 and in September 2008 received practice expense recommendation from a specialty society for review at the October 2008 RUC meeting.

36481
The RUC reviewed the direct practice expense inputs recommendation for code 36481 from the specialty society and determined that the medical supplies and equipment time included in the recommendation overlapped other services, such as imaging services, that are typically billed at the same time. The RUC also determined the specialty society recommendation lacked RUC standards for practice expense and that other similar services recently reviewed by the RUC may require revised recommendations. Based on these issues the RUC could not make an informed recommendation at this time. **The RUC recommends that the specialty society develop a revised direct practice expense input recommendation for code 36481 and all codes typically billed with code 36481 (to be determined) for presentation at the next RUC meeting. The RUC also recommends this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

37183
The RUC reviewed the specialty society direct practice expense inputs recommendation for code 37183 and made several edits in clinical staff types and time to be more reflective of the service. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 37183 and recommends that this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

47382
The RUC reviewed the specialty society direct practice expense inputs recommendation for code 37183 and made several edits in clinical staff types for the typical patient scenario. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 47382 and recommends that this service be placed on the CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

50200
The RUC reviewed the specialty society direct practice expense inputs recommendation for code 50200 and made edits in clinical staff types and time to reflect the typical patient encounter. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 50200 and recommends that this service be placed on the CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

1759

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
⊙36481	Percutaneous portal vein catheterization by any method	000	Review of PE Only
⊙37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated	000	Review of PE Only
⊙47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	010	Review of PE Only
⊙50200	Renal biopsy; percutaneous, by trocar or needle	000	Review of PE Only

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**37183**	
2		**CMS**	**Staff**	**Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**000**	**000**
5	**TOTAL TIMES BY STAFF TYPE**				
6		**L037D**	**RN/LPN/MTA**	**26.0**	**13.0**
7		**L041A**	**Angio Tech**	**99.5**	**0.0**
8		**L051A**	**RN**	**144.5**	**0.0**
9	**TOTAL CLINICAL LABOR TIME**			**270.0**	**13.0**
10	**TOTAL CLINICAL LABOR TIME**			**268.0**	**13.0**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**14.0**	**10.0**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**251.0**	**0.0**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**3.0**	**3.0**
14	**PRE-SERVICE**				
15	**Start: Following visit when decision for surgery or procedure made**				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**
17	Coordinate pre-surgery services				
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA	**3**	**5**
19	Provide pre-service education/obtain consent				
20	Follow-up phone calls & prescriptions				
21	Other Clinical Activity (please specify) - Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting M	L041A	Angio Tech	**6**	
22	**End: When patient enters office/facility for surgery/procedure**				
23	**SERVICE PERIOD**				
24	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedur**				
25	Review charts	L037D	RN/LPN/MTA	**2**	
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	**3**	
27	Obtain vital signs	L037D	RN/LPN/MTA	**5**	
28	Provide pre-service education/obtain consent				
29	Prepare room, equipment, supplies	L041A	Angio Tech	**4**	
30	Setup scope (non facility setting only)				
31	Prepare and position patient/ monitor patient/ set up IV	L037D	**RN/LPN/MTA**	**2**	
32	Sedate/apply anesthesia	L051A	**RN**	**2**	
33	**Intra-service**				
34	Assist physician in performing procedure - CS	L051A	RN	**77.5**	
35	Assist physician in performing procedure	L041A	Angio Tech	**77.5**	
36	**Post-Service**				
37	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	**60**	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**	
39	Clean Scope				
40	Clean Surgical Instrument Package				
41	Complete diagnostic forms, lab & X-ray requisitions	L041A	Angio Tech	**5**	
42	Review/read X-ray, lab, and pathology reports				
43	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L051A	RN	**3**	
44	Discharge day management				
45	Other Clinical Activity (please specify): post procedure imaging processing	L041A	Angio Tech	**7**	
46	**End: Patient leaves office**				
47	**POST-SERVICE PERIOD**				
48	**Start: Patient leaves office/facility**				
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**3**	**3**
50	*Office visits:*				
51	*List Number and Level of Office Visits*				
52	99211 16 minutes		16		
53	99212 27 minutes		27		
54	99213 36 minutes		36		
55	99214 53 minutes		53		
56	99215 63 minutes		63		
57	Other				
58	*Total Office Visit Time*			**0**	**0**
59	Other Activity (please specify)				
60	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**37183**	
2		**CMS**	**Staff**	**Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
61	[redacted]				
62	pack, minimum multi-specialty visit	SA048	pack	1	
63	pack, conscious sedation	SA044	pack	1	
64	kit, IV starter	SA019	kit	1	
65	gown, surgical, sterile	SB028	item	2	
66	gloves, sterile	SB024	pair	3	
67	mask, surgical, with face shield	SB034	item	2	
68	cap, surgical	SB001	item	2	
69	shoe covers, surgical	SB039	pair	2	
70	tray, shave prep	SA067	tray	1	
71	underpad 2ftx3ft (Chux)	SB044	item	1	
72	drape, sterile, femoral	SB009	item	1	
73	drape-towel, sterile 18inx26in	SB019	item	4	
74	Betadine	SJ041	ml	60	
75	applicator, sponge-tipped	SG009	item	4	
76	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10	
77	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2	
78	heparin 1,000 units-ml inj	SH039	ml	5	
79	sodium chloride 0.9% flush syringe	SH065	item	2	
80	closed flush system, angiography	SC010	item	1	
81	catheter, angiographic, pig-tail	SC008	item	1	
82	blade, surgical (Bard-Parker)	SF007	item	1	
83	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1	
84	guidewire, hydrophilic (Glidewire)	SD089	item	1	
85	guidewire, (Bentson)	SD172	item	1	
86	guidewire (Transcend)	SD175	item	1	
87	microcatheter guidewire introducer	SA016	item	1	
88	vascular sheath	SD136	item	2	
89	catheter microcatheter selective	SD154	item	1	
90	catheter (SIM2F1)	SD148	item	1	
91	catheter, curved (Headhunter)	SD153	item	1	
92	catheter (Glide)	SD147	item	1	
93	steri-strip (6 strip uou)	SG074	item	1	
94	sterile bowl	SD171	item	2	
95	gauze, sterile 4in x 4in	SG055	item	2	
96	dressing 3 X 4 wound care telfa	SG035	item	2	
97	tape, surgical paper 1in (Micropore)	SG079	item	6	
98	drape, sterile, c-arm, fluoro	SB008	item	1	
99	~~Tegaderm dressing~~	~~SG037~~	~~item~~	~~0~~	
100	~~Conray Inj (iothalamate 43%)~~	~~SH026~~	~~ml~~	~~60~~	
101	biohazard bag	SM004	item	2	
102	~~film, x-ray 14inx17in~~	~~SK034~~	~~item~~	~~6~~	
103	~~x-ray envelope~~	~~SK091~~	~~item~~	~~1~~	
104	~~x-ray developer solution~~	~~SK089~~	~~oz~~	~~6~~	
105	~~x-ray fixer solution~~	~~SK092~~	~~oz~~	~~6~~	
106	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1	
107	computer media, dvd	SK013	item	1	
108	**stent, VIATORR manufacturer GORE Contact Antoinette Sheen)**	**NEW**	**item**	1	
109	[redacted]				
110	room, angiography	EL011		1	
111	~~film alternator (motorized film viewbox)~~	~~ER029~~		~~1~~	
112	stretcher	EF018		1	

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**47382**	
2		**CMS**	**Staff**	**Ablation, one or more liver tumor(s), percutaneous, radiofrequency**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**010**	**010**
5	**TOTAL TIMES BY STAFF TYPE**				
6		**L037D**	**RN/LPN/MTA**	**52.0**	**23.0**
7		**L041B**	**RT**	**153.0**	**0.0**
8		**L051A**	**RN**	**197.0**	**27.0**
9	**TOTAL CLINICAL LABOR TIME**			**402.0**	**50.0**
10	**TOTAL CLINICAL LABOR TIME**			**409.0**	**50.0**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**14.0**	**23.0**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**368.0**	**0.0**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**27.0**	**27.0**
14	**PRE-SERVICE**				
15	**Start: Following visit when decision for surgery or procedure made**				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**
17	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**3**	**10**
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**5**
19	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**	
20	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**3**	**3**
21	Other Clinical Activity (please specify)				
22	**End: When patient enters office/facility for surgery/procedure**				
23	**SERVICE PERIOD**				
24	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedu**				
25	Review charts	L037D	RN/LPN/MTA	**3**	
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	**3**	
27	Obtain vital signs	L037D	RN/LPN/MTA	**5**	
28	Provide pre-service education/obtain consent	L041B	RT	**2**	
29	Prepare room, equipment, supplies	L041B	RT	**2**	
30	Setup scope (non facility setting only)	L041B	RT	**0**	
31	Prepare and position patient/ monitor patient/ set up IV	L051A	RN	**2**	
32	Sedate/apply anesthesia				
33	**Intra-service**				
34	Assist physician in performing procedure - CS	L051A	RN	**180**	
35	Assist physician in performing procedure	L041B	RT	**144**	
36	**Post-Service**				
37	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	**15**	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**1**	
39	Clean Scope	L041B	RT	**5**	
40	Clean Surgical Instrument Package				
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	**3**	
42	Review/read X-ray, lab, and pathology reports				
43	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**	
44	Discharge day management				
45	Other Clinical Activity (please specify)				
46	**End: Patient leaves office**				
47	**POST-SERVICE Period**				
48	**Start: Patient leaves office/facility**				
49	Conduct phone calls/call in prescriptions				
50	*List Number and Level of Office Visits*				
51	99211 16 minutes		16		
52	99212 27 minutes	L037D	RN/LPN/MTA	**1**	**1**
53	99213 36 minutes		36		
54	99214 53 minutes		53		
55	99215 63 minutes		63		
56	Other				
57	*Total Office Visit Time*			**27**	**27**
58	Other Activity (please specify)				
59	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**47382**	
2		**CMS**	**Staff**	**Ablation, one or more liver tumor(s), percutaneous, radiofrequency**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
60	MEDICAL SUPPLIES		Unit		
61	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1	
62	applicator, sponge-tipped	SG009	item	4	
63	tape, surgical paper 1in (Micropore)	SG079	inch	12	
64	gauze, sterile 4in x 4in	SG055	item	3	
65	povidone soln (Betadine)	SJ041	ml	60	
66	tray, shave prep	SA067	tray	1	
67	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10	
68	mask, surgical, with face shield	SB034	item	2	
69	drape, sterile, fenestrated 16in x 29in	SB011	item	1	
70	gloves, sterile	SB024	pair	2	
71	drape-towel, sterile 18in x 26in	SB019	item	1	
72	pack, minimum multi-specialty visit	SA048	pack	2	
73	pack, conscious sedation	SA044	pack	1	
74	syringe 10-12ml	SC051	item	1	
75	drape, sterile, three-quarter sheet	SB014	item	1	
76	cup-container, sterile, graduated 1000ml	SL038	item	1	
77	scalpel with blade, surgical (#10-20)	SF033	item	1	
78	needle, 18-27g	SC029	item	2	
79	probe, radiofrequency, 3 array (StarBurstSDE)	SD109	item	1	
80	NEW- probe, radiofrequency Xli-Enhanced RF Probe, $2695.00, manufacturer; AngioDynamics [The Xli-Enhanced RF Probe, typical for liver RFA, is larger than the SD109- probe, radiofrequency, 3 array (StarBurstSDE) used for renal, pulmonary and bone RFA procedures. Cost information provided by Jeff Maudlin, Angiodynamics, Oncology Products Group, (727) 631-4517, jmaudlin@angiodynamics.com]	NEW	item	1	
81	NEW - Kit, radiofrequency introducer for Xli-Enhanced RF Probe, $99.00, manufacturer- AngioDynamics [The Xli-Enhanced RF Probe introducer is different than SA026 and is specific for use with the larger Xli-Enhanced RF Probe presented above.]	NEW	item	1	
82	silver nitrate applicator	SJ046	item	1	
83	tray, biopsy procedure	SA061	tray	1	
84	cup, biopsy-specimen sterile 4oz	SL036	item	1	
85	water, sterile for irrigation (250-1000ml uou)	SG074	item	1	
86	tincture of benzoin, swab	SJ060	item	1	
87	syringe 20ml	SC053	item	1	
88	gown, surgical, sterile	SB028	item	2	
89	shoe covers, surgical	SB039	pair	2	
90	underpad 2ft x 3ft (Chux)	SB044	item	1	
91	Equipment	CMS Code			
92	room, CT	EL007		1	
93	New Equipment - Angiodynamics Radiofrequency Generator ($37,500) Jeff Maudlin, Angiodynamics, Oncology Products Group, (727) 631-4517, jmaudlin@angiodynamics.com	NEW		1	
94	New Equipment - Radiofrequency Infusion Pump ($5,995) Jeff Maudlin, Angiodynamics, Oncology Products Group, (727) 631-4517, jmaudlin@angiodynamics.com	NEW		1	
95	table, exam	EF023		1	

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**50200**	
2		**CMS**	**Staff**	**Renal biopsy;**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**000**	**000**
5	**TOTAL TIMES BY STAFF TYPE**				
6		**L037D**	**RN/LPN/MTA**	**34.0**	**26.0**
7		**L041B**	**RT**	**49.4**	
8		**L051A**	**RN**	**70.0**	
9	**TOTAL CLINICAL LABOR TIME**			**153.4**	**26.0**
10	**TOTAL CLINICAL LABOR TIME**			**155.4**	**26.0**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**14.0**	**26.0**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**141.4**	**0.0**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
14	**PRE-SERVICE**				
15	**Start: Following visit when decision for surgery or procedure made**				
16	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	**5**	**5**
17	Coordinate pre-surgery services	L037D	RN/LPN/MTA	**3**	**10**
18	Schedule space and equipment in facility	L037D	RN/LPN/MTA		**5**
19	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	**3**	**3**
20	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	**3**	**3**
21	Other Clinical Activity (please specify)				
22	**End: When patient enters office/facility for surgery/procedure**				
23	**SERVICE PERIOD**				
24	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedu**				
25	Review charts	L037D	RN/LPN/MTA	**3**	
26	Greet patient and provide gowning	L037D	RN/LPN/MTA	**3**	
27	Obtain vital signs	L037D	RN/LPN/MTA	**5**	
28	Provide pre-service education/obtain consent	L041B	RT	**2**	
29	Prepare room, equipment, supplies	L041B	RT	**2**	
30	Setup scope (non facility setting only)				
31	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**2**	
32	Sedate/apply anesthesia	L051A	RN	**2**	
33	**Intra-service**				
34	Assist physician in performing procedure - CS	L051A	RN	**53**	
35	Assist physician in performing procedure	L041B	RT	**42**	
36	**Post-Service**				
37	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	**15**	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**1**	
39	Clean Scope	L041B	RT	**5**	
40	Clean Surgical Instrument Package				
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	**3**	
42	Review/read X-ray, lab, and pathology reports				
43	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**3**	
44	Discharge day management				
45	Other Clinical Activity (please specify)				
46	**End: Patient leaves office**				
47	**POST-SERVICE Period**				
48	**Start: Patient leaves office/facility**				
49	Conduct phone calls/call in prescriptions				
50	*Office visits:*				
51	*List Number and Level of Office Visits*				
52	99211 16 minutes		16		
53	99212 27 minutes		27		
54	99213 36 minutes		36		
55	99214 53 minutes		53		
56	99215 63 minutes		63		
57	Other				
58	*Total Office Visit Time*			**0**	**0**
59	Other Activity (please specify)				
60	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**50200**	
2		**CMS**	**Staff**	**Renal biopsy;**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
61	MEDICAL SUPPLIES				
62	pack minimum multi-specialty visit	SA048	pack	1	
63	pack, conscious sedation	SA044	pack	1	
64	angiocatheter 14g-24g	SC001	item	1	
65	heparin lock	SC012	item	1	
66	needle, 18-27g	SC029	item	1	
67	needle, biopsy, spring-loaded	SC033	item	1	
68	syringe 5-6 ml	SC057	item	1	
69	tray, biopsy procedure	SA061	tray	1	
70	povidone solution (Betadine)	SJ041	ml	30	
71	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10	
72	sodium chloride 0.9% flush syringe	SH065	item	1	
73	bandage, strip 0.75 x 3 in (Bandaid)	SG021	item	1	
74	drape, sterile, for Mayo stand	SB012	item	1	
75	gloves, sterile	SB024	pair	2	
76	pillow case	SB037	item	0	
77	sterile gown	SB028	item	2	
78	surgical mask	SB033	item	2	
79	biohazard bag	SM004	item	1	
80	cup, biopsy-specimen sterile 4 oz	SL036	item	1	
81	cytology, preservative and vial	SL040	item	3	
82	Equipment				
83	room, CT	EL007		1	
84	mayo stand	EF015		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Arteriovenous Procedures

CPT code 36825, *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft*, was identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, The RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

1770

The RUC first reviewed 36825 to determine if there was compelling evidence to justify a review of the work RVU for a potential increase in value. The specialty society indicated that the service had never been reviewed by the RUC and was originally valued during the Harvard studies. Additionally, the specialty commented that the work involved in the procedure has changed due to a change in the typical patient since its inception. The procedure, which is used to create access for hemodialysis patients, is used less frequently now and on much more complicated patients, than it was in the past. Because of the "fistula first" initiative, patients are typically not undergoing this procedure unless they have failed a direct anastomosis. Since this is a secondary procedure, the patients that undergo a 36825 are typically older, sicker, and have no available hemodialysis access in their arms. Therefore, the physician work has changed. **The RUC agreed that compelling evidence to consider the revaluation of 36825.**

The specialty society presented the data from a survey of 31 general and vascular surgeons. The RUC first reviewed the physician time and post-operative evaluation and management visits. According to the survey, 74% of patients are kept overnight and more than 80% of those patients are seen on the evening of the day of the procedure and again the following day before being discharged. Because of this survey data, the RUC agreed that 36825 includes a full 99238 discharge day management visit as well as one 99231 hospital visit. The RUC also agreed with the survey post-service office visits, which include one 99212 and two 99213 visits. The

RUC also agreed with the survey median intra-service time of 120 minutes, the survey median immediate post-service time of 30 minutes, and pre-service time package #4, difficult patient/difficult procedure, with an additional seven minutes of positioning time. Lastly, the RUC reviewed the recommended work RVU and disagreed with the specialty society expert panel recommendation. The RUC considered the survey data in comparison to the MPC reference code selected by the specialty, 36819, *Arteriovenous anastomosis, open; by upper arm basilic vein transposition*, (work RVU = 14.39). The RUC agreed that the survey median work RVU of 18.00 was too high, but that the survey 25th percentile work RVU was appropriate. The RUC reviewed 36819 and noted that the reference service and the surveyed code contain identical intra-service times of 120 minutes. The specialty noted that there are two differences between 36825 and 36819 that warrant a higher RVU for 36825: (1) 36825 requires a vein that is harvested from a remote location. As a result, it requires two anastomoses, one where the vein is sewn to the inflow artery and a second where it is attached to the outflow vein. (2) The surveyed code includes an additional 99213 office visit. As a result, the RUC agreed that the survey 25th percentile work RVU of 15.00 is appropriate in comparison to 36819 for 36825. **The RUC recommends the specialty's survey 25th percentile work RVU of 15.00 for CPT code 36825.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

1771

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
36820	Arteriovenous anastomosis, open; by forearm vein transposition	090	14.39 (No Change)
36821	direct, any site (eg, Cimino type) (separate procedure)	090	12.00 (No Change)
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	090	15.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:36825 Tracking Number Specialty Society Recommended RVU: **16.19**

Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Creation of Arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous graft

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old man undergoes chronic hemodialysis for longstanding renal failure due to renovascular occlusive disease. He has undergone 4 prior native arteriovenous fistulas over the last 8 years, all of which eventually failed. Placement of a new arteriovenous hemoaccess is undertaken in his forearm using greater saphenous vein. Note: the work of this procedure includes vein harvest. Vein harvest is not separately reportable.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 26% , Kept overnight (less than 24 hours) 35% , Admitted (more than 24 hours) 39%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 82%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 26%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service 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, electrolytes, BUN, creatinine etc. in the ESRD patient. The peripheral vascular exam and the preoperative diagnostic studies are reviewed. Final 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 donor vein conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site and the implantation 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:
Arterial Inflow Dissection: Incise skin overlying target inflow artery. Dissect soft tissue to expose artery, avoid injury to multiple nearby nerves & veins. Clear soft tissue from artery for ~6 cm length. Pass soft loops around artery for control.

Venous Outflow Dissection: Incise skin overlying previously identified outflow vein. Dissect soft tissue from around the vein, avoiding nerve/arterial injury. Pass soft rubber loops around artery for control. Create a tunnel from arterial dissection site to vein dissection site in subcutaneous tissue of the forearm.

Harvest Vein Conduit: Incise skin of thigh/calf over donor conduit vein (typically greater saphenous vein). Identify vein. Clear soft tissue from around vein for adequate length. Ligate and divide all vein branches. Ligate and divide ends of vein after double-checking to ensure adequate length has been harvested, and remove vein fr extremity. Test vein conduit for leaks & repair same as needed with 7-0 vascular suture.

Arterial Anastomosis: Anticoagulate patient with IV heparin and wait for circulation time. Apply vascular clamps to arterial anastomosis site on inflow artery. Perform arteriotomy. Perform most of vein conduit to inflow 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 outflow vein anastomosis site with care to avoid twists/kinks.

Venous Outflow Anastomosis: Stretch vein conduit to full length. Apply vascular clamps. Perform venotomy. Cut vein conduit to match length and size of ventomy. Perform most of vein-to-vein 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 fistula patency and assure continued flow to hand after completing the fistula. Irrigate all incisions. Achieve final wound hemostasis. Close all 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. Discuss results of procedure with patient once he/she is fully awake.

Depending on the preexisting comorbidities and operative course the patient may require full hospital admission overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recove area discharge criteria are met.

If the patient is admitted to hospital or is required to remain in the facility overnight, an E&M service is provided at the end of the work day to assure that the patient is hemodynamically stable, to assess neurovascular status of the hand on the limb where the hemoaccess was created, and to assure there is no significant bleeding from either the arterial or venous anastomosis. Blood test evaluation and discussion with the nephrologist regarding need for hemodialysis is also typical.

During remainder of patient stay, the physician makes follow-up visits as clinically required, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Care it taken to ensure patency of the fistula in addition to adequate blood flow to hand. 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.

At follow-up office visits: Examine and talk with patient. Remove staples or sutures, when appropriate. Review activity and restrictions. Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family. Check for presence of post-operative hematoma/seroma. Check for patency of fistula and adequacy of blood flow to hand. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Gary Seabrook MD FACS, Matthew Sideman MD FACS, David Han MD FACS, Robert Zwolak MD FACS, Michael Sutherland MD FACS, Christopher Senkowski, MD, FACS				
Specialty(s):	General Surgery, Vascular Surgery				
CPT Code:	36825				
Sample Size:	100	**Resp N:**	31	**Response:** 31.0 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	1.00	5.00
Survey RVW:	14.00	15.00	**18.00**	22.25	28.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	90.00	110.00	**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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	36825	**Recommended Physician Work RVU: 15.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
35522	090	23.05	**RUC Time**

CPT Descriptor Bypass graft, with vein; axillary-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	Work RVU	Time Source	Most Recent Medicare Utilization
36819	090	14.39	**RUC Time**	12,093

CPT Descriptor 1 Arteriovenous anastomosis, open; by upper arm basilic vein transposition

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 51.6 %

TIME ESTIMATES (Median)	CPT Code: 36825	Key Reference CPT Code: 35522	Source of Time RUC Time
Median Pre-Service Time	70.00	103.00	
Median Intra-Service Time	120.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	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	**340.00**	**497.00**	
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	3.42	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.25
Urgency of medical decision making	3.08	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.25
Physical effort required	3.33	3.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.92	3.67
Outcome depends on the skill and judgment of physician	4.33	4.08
Estimated risk of malpractice suit with poor outcome	3.50	3.42

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.42	3.08
Intra-Service intensity/complexity	3.78	3.33
Post-Service intensity/complexity	2.92	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.*

RVW RECOMMENDATION: Our recommended RVW of 16.19 is mid-way between the survey 25th percentile (15.00) and the median survey value (18.00). It is constructed based on comparison to a very similar hemoaccess operation (36819) that has been RUC surveyed and also serves on the MPC-list.

HISTORY: 36825 was identified by the 5-year review ID workgroup in 2007 as a site-of-service anomaly because the Harvard inputs contained in-patient visits, yet the Medicare data suggested only 38% of cases were performed under true in-patient status. This was one of the few remaining vascular surgery services that had never undergone RUC survey, and we therefore conducted a survey in preparation for the February **2008** RUC meeting. Following initial presenta at Feb '08 RUC we requested the code be withdrawn until a discussion could be undertaken regarding procedures v overnight stays, the so-called 23hr-59min issue. For the Feb 2009 RUC meeting we re-surveyed this code. Interestingly, surveying the same code one year apart with different respondents yielded a slightly higher median RVW (18.00 now compared to 17.25 one year ago) and a slightly lower median intra-service time (120 min now compared to 140 min a year ago), with no major change in visits.

COMPELLING EVIDENCE: Since we believe an increase in RVW is indicated for this service that has not previously undergone RUC survey, we present compelling evidence:

1. Vascular Surgery was not recognized by Harvard As outlined in detail by Hertzer and Noether, the Hsiao/Harvard team that developed the RBRVS failed to recognize peripheral vascular surgery as a distinct discipline.[1] The physician work RVWs for 170 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations in Harvard Phase 1 (infrarenal aortic aneurysm repair and carotid endarterectomy). Upon thorough analysis of the Harvard/Hsiao extrapolations it became clear that physicians evaluating the vascular surgery services were not even obligated to have a working knowledge of the services as a condition for participation. The lack of an adequate basis for setting relative value work units for vascular services has been a widely acknowledged problem, resulting in reconsideration more than 100 vascular services during the first three 5-year reviews.

In the early phases of RBRVS development, peripheral vascular CPT codes were grouped with cardiac surgery. This was an especially unfortunate situation since cardiac operations (but not peripheral vascular procedures) had long been targets of critics who felt they were overcompensated. As a result, RVI assignments resulted in major reductions in Medicare payment. Medicare has since acknowledged tl cardiothoracic and vascular surgery procedures are fundamentally distinct, but in the late 1980s many physicians and non-physicians had difficulty understanding the difference between a "cardiothoracic surgeon" and a "vascular surgeon". Thus, it is not surprising that the initial physician RVWs in vascular surgery were low overall and contained undeniable rank order anomalies. As an example of an overt rank order anomaly within the initial vascular surgery RVWs, elective repair of an infrarenal aortic aneurysm extending into the iliac arteries and requiring a bifurcated prosthesis was assigned a lower RVW than tube graft repair of an aneurysm isolated to the infrarenal aorta.

Much the same is true for general surgery. The American College of Surgeons was not a participant in the Harvard studies that form the foundation of RBRVS. General surgery has therefore been working for 15-years, through three 5-year review processes to achieve parity. Like vascular, the general surgeons have submitted hundreds of services for review, with acknowledgement during each review that their services had been generally undervalued by Harvard. The current service is performed by general surgeons and vascular surgeons. While the RUC database states that it was considered in 1995 during the first 5-year review, the service did not undergo RUC survey, and only very sketchy details are presented under RUC rationale. We propose that 36825 has not undergone RUC survey and that it meets the compelling evidence threshold to be considered from a 5-year review perspective.

2. The work of this service has changed. While we believe this service was never valued correctly to begin with, the fact is that the work of 36825 has increased since inception of RBRVS. Numerous scientific publications have identified native autogenous hemodialysis access (such as 36825) as providing greater protection against infection in these very sick dialysis patients. This has become so important to CMS that th Agency created the Fistula First Breakthrough Initiative (FFBI), an entity that has been extremely influential urging surgeons to perform native autogenous access in an increasing percentage of dialysis patients. What this means is that surgeons are performing more and more complex operations to meet the CMS FFBI mandate.

[1] Hertzer NR, Noether MG. The resource-based relative value scale in vascular surgery. A report of the activities of the Joint Council of the Society for Vascular Surgery and the North American Chapter of the ISCVS. J Vasc Surg 1993; 18:692-701.

Therefore, while in earlier times surgeons would only perform native dialysis fistulas on the healthiest patients with large veins and normal arteries, the fact is that smaller and more diseased veins and arteries are being used to create native fistulas. This is reflected in greater skin-to-skin operative times and greater levels of complexity.

3. Fistula performance is now a Quality Performance Indicator. As indicated in the K-DOQI guidelines for hemodialysis access, and with support from the Fistula First Breakthrough Initiative, performance of native hemodialysis access fistulas such as 36825 is now a formal Quality Indicator based on consideration of the National Quality Foundation. This important step will push surgeons even more towards performing an increasing percentage of native fistulas with greater emphasis on functionality of the finished product. This all translates to more time, more intensity, and therefore, more work.

WHAT IS THE TYPICAL HOSPITAL STAY PATTERN? Our survey data indicate that this service is provided in three distinct hospital stay patterns. By survey, the plurality of patients (39%) undergoes formal hospital admission and retains in-patient status. This compares well to the 2007 RUC database Medicare hospital admission rate of 38%. Next most common pattern by survey is an overnight stay (35%), while least common is discharge from hospital on the same day, only 26%. We therefore concluded that presenting this code to the RUC as an everyday "outpatient" procedure would be inaccurate.

In fact, this range of hospital patterns makes it difficult to describe the "typical" patient in terms of hospital stay or physician work. If you believe the three patterns of hospital stay reflect different physician work – which we do – then the "most typical" patient would be admitted to the hospital. On the other hand, if you choose to lump overnight stay with same day discharge, then the lumped group is more common. It is important to state that the main driver of hospital stay is the number and severity of comorbidities in the elderly ESRD patient.

Based on the reality that post-op ESRD patients are fragile and require close attention to avoid calamity, and the fact that 74% of patients are physically in the hospital for two days, our recommendation for constructing this work RVU ncludes one 99231 inpatient visit plus one full 99238 discharge day service.

COMPARISON WITH KEY REFERENCE: 35522 was chosen as key reference service by 52% of respondents. It is a RUC-surveyed service with an RVW of 23.05. 35522 is a clinically similar upper extremity bypass graft that involves analogous surgical steps including dissection of arteries in the arm, harvest of vein conduit, and construction of two separate vascular anastomosis All this is done with vigilant avoidance of injury to adjacent arteries, nerves and veins in the upper extremity. Intensity and complexity measures of the two codes are very similar, as documented above. 35522 has a longer intra-service time than 36825 (180 vs. 120 minutes). 35522 also has two level two (99232) in-patient visits and one less office visit (99212) that are not in 36825. An RVW for 36825 can be estimated by starting with the RVW of the 35522 key reference (23.05) and subtracting the two 99232 hospital visits (-2.78), subtracting 60 minutes of intra-time at the IWPUT of that service (60x0.077=4.62), and adding the office visit (+0.45). The value calculates out to 23.05-2.78-4.62+0.45=16.10. Thus, straightforward comparison with the key reference service justifies an RVW for 36825of at least 16.10.

COMPARISON WITH MPC SERVICE: 36819 is an MPC list hemodialysis access service surveyed by the RUC in 1999. It has an RVW of 14.39. 36819 has the same intra-service time (120 min) as the just-surveyed 36825. In addition, both codes have one 99231 and one 99238. 36825 has one additional office visit (99213 – much older and sicker patient with leg incision in addition to arm incision). In addition 36825 has 25 extra pre-service minutes (older, sicker, must evaluate leg donor vein, hold, prep and drape leg) and 15 extra immediate post-service minutes (older, sicker, second incision, assure leg donor site dry, etc). Thus, an RVW for 36825 can be built by starting with the RVW for 36819 (14.39) and adding one 99213 (0.92) and 40 pre and post minutes at 0.022 RVUs/min (40*0.022 = 0.88. **We believe this calculation (14.39 + 0.92 + 0.88 = 16.19) is the best estimate of an accurate RVW for 36825.**

WPUT for the recommended RVW of 16.19 is 0.083, fully consistent with other native fistula hemodialysis access operations.

7-MINUTES EXTRA PRE-SERVICE TIME BEYOND PACKAGE: The typical patient for this last-gasp fistula operation is old and slow-moving. He/she needs to be positioned on the OR table such that two extremities (one arm &

one leg) can be sterilely prepped and remain fully accessible to the operating surgeon. Seven minutes of extra time is a conservative estimate.

INPATIENT VISIT ON THE DAY OF SURGERY: This operation is pretty much the end of the line in native fis procedures for the ESRD patient. The typical patient has undergone multiple prior hemoaccess operations an physiologically aged well beyond his 75 chronologic years. This is not the patient you tip your hat to on the way out the door at night. He or she requires a substantial assessment to ensure the fistula is patent, the hand beyond the fistula is not ischemic, and that all hemodynamic instability and electrolyte abnormalities have been avoided.

FULL DISCHARGE DAY: A full discharge visit (99238) is warranted for this service whether the patient goes home on the day of service or the day after. Discharge work includes a full neurovascular evaluation of the extremity, wound evaluation for potential hemorrhage, fistula evaluation to ensure patency, glycemic assessment, physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into CHF, provision of wound care instructions, provision of warnings for vascular steal syndrome and/or vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick subset of typically diabetic renal failure patients. Simply because the RUC "convention" is ½ discharge day for "outpatient" services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. We recommend one full 99238.

COMPARISON WITH OTHER HEMOACCESS OPERATIONS: 36825 is the most intense and complex hemoaccess service that employs native autogenous vein conduit for which a category I CPT code exists. Here is the current list of RUC-surveyed native access codes. 36825 deserves the highest RVW to avoid a rank order anomaly:

36818 Upper arm cephalic vein transposition	RVW 11.81
36819 Upper arm basilic vein transposition	RVW 14.39
36820 Forearm vein transposition	RVW 14.39
36821 Direct Cimino type fistula	RVW 12.00
36825 AV fistula by autogenous graft	RVW 16.19 recommended

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 36825 is an existing Category I CPT code

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 GS How often? Rarely

Specialty VS How often? Rarely

Specialty TS/CTS How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 6000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Medicare data

Specialty GS Frequency 3100 Percentage 51.66 %

Specialty VS Frequency 1700 Percentage 28.33 %

Specialty TS/CTS Frequency 900 Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
6,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. Medicare data

Specialty GS Frequency 3100 Percentage 51.66 %

Specialty VS Frequency 1700 Percentage 28.33 %

Specialty TS/CTS Frequency 900 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. 36819

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings								Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings								Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1		60	0	L037D			4	0		0			-1	1		Yes	9
28120	50	50	1	0	3	2	0	67	-17	L037D	1	0	3.5	0	0	-17	0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0	51	-6	L037D	1	0	5	0	0	-6	0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0	60	30	L037D	1	0	4	0	0	0	0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0	120	-20	L037D	1	0	0	5	0	0	0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0	81	39	L037D	1	0	2.5	0	0	0	0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0	156	-6	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0	182	-2	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0	67.5	2.5	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0	90	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0	60	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
69100	12	8						10	2	L037D						1						No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Parotid Tumor Excision

CPT codes 42415, *Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve and 42420, Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

1784

42415
The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 42415. However, the specialty presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 97% of respondents perform the procedure in the hospital. Of those 97% respondents, 91% stated that the patient stays overnight. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. The specialty societies indicated that an additional 9 minutes of positioning time is necessary to assist the patient with the shoulder roll, rotating and stabilizing the head. Further, the survey and panel, based on the survey median, recommended an intra-service time of 150 minutes and immediate post-service time of 20 minutes. Lastly, the specialty presented data that one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC also compared 42415 to the key reference service, 60271, *Thyroidectomy, including substernal thyroid; cervical approach*, (work RVU =

17.54, intra-time = 150), which supports the current work RVU of 17.99. The RUC also noted that the survey 25th percentile work RVU was 18.00. **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 17.99 for CPT code 42415.**

42420

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 42420. However, the specialty presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 100% of respondents perform the procedure in the hospital. Of those respondents, 98% stated that the patient stays overnight, and 62% stated that the patient stays longer than one day. The consensus panel indicated that the typical length of stay for this procedure is 3 days monitoring for airway patency, hematoma formation, facial nerve function, and control of pain and nausea is necessary. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. The specialty societies indicated that an additional 9 minutes of positioning time is necessary to assist the patient with the shoulder roll, rotating and stabilizing the head. Further, the survey and panel, based on the survey median, recommended an intra-service time of 180 minutes and immediate post-service time of 20 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99232 hospital visit, one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared the 42420 to MPC code 35141, *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 femoris, superficial femoral),* (work RVU = 20.83, intra-time = 150 minutes) and code 34471, *Thrombectomy, direct or with catheter; subclavian vein, by neck incision* (work RVU = 21.00 intra-service = 180) and agreed that the two services support the current work RVU of 20.87. The RUC also noted that the survey respondents indicated a median work RVU of 25.00 work RVUs and a 25th percentile of 23.36, comparing the work of 42420 to 38724, *Cervical lymphadenectomy (modified radical neck dissection)* (work RVU = 23.72). **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 20.87 for CPT code 42420.**

1785

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
42415		Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	090	17.99 (No Change)
42420		total, with dissection and preservation of facial nerve	090	20.87 (No Change)

1786

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:42415 Tracking Number Specialty Society Recommended RVU: **17.99**

Global Period: 090 RUC Recommended RVU: **17.99**

CPT Descriptor: Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents with a 2-year history of a slow growing 2 centimeter mass in the right preauricular region 1.5 centimeter anterior to the tragus. There is no pain, facial weakness, history of infection. A CT scan shows a mass in the superficial lobe of the parotid gland. Fine needle biopsy is compatible with a pleomorphic adenoma. A superficial parotidectomy with dissection and preservation of the facial nerve is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 3%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 9% , Kept overnight (less than 24 hours) 57% , Admitted (more than 24 hours) 34%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 43%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review medical history, pathology, and radiology report. Review radiographic images. Review results of preoperative testing (labs, EKG, CXR). Review reports of consultants providing preoperative assessment and clearance as indicated. Meet with patient and family to review planned procedure and postoperative management. Reexamine patient to ensure that physical findings have not changed and dictate history and physical. Obtain informed consent. Review hospital consent, mark patient. Review airway and medical management with anesthesiologist. Review planned procedure with OR staff. Verify that all required instruments and supplies are available. Change into scrub clothes. Monitor/assist with positioning of the patient. Ensure that radiographic images are available in the OR. Mark planned incision. Inject planned incision with vasoconstrictor. Monitor/assist with prepping and draping. Scrub and gown. Perform surgical "time out" with operating surgical team.Place facial nerve monitor.

Description of Intra-Service Work: Under anesthesia, a preauricular incision is made with curved cervical extensi below the angle of the mandible. Anterior and posterior skin flaps are elevated in the subplatysmal plane, superficial the parotid fascia, exposing the parotid gland and the sternocleidomastoid muscle. The parotid gland is dissected from the anterior border of the sternocleidomastoid muscle and the greater auricular nerve is transected. The gland is dissected from the mastoid process and the cartilage of the external auditory canal. The main trunk of the facial nerve is identified and protected. Facial nerve stimulation is performed as needed at various points during the procedure. The

overlying parotid tissue is elevated from the main trunk of the facial nerve to expose the bifurcation. The peripheral branches of the facial nerve are sequentially dissected, separating the overlying parotid tissue from the facial nerve and deep lobe of the gland. The lobe and associated tissue are removed and sent to pathology. All structures are inspected including the facial nerve. A deep drain is placed and the wound closed in layers.

Description of Post-Service Work: Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure proper drain function and assess facial nerve function. Write postoperative note. Dictate operative note and copy to referring physician. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Examine patient, check wound and patient progress - Monitor closely for airway patency and for development of cervical hematoma. Write orders for postoperative medications, diet, and patient activity. Check wounds, change dressings, and monitor patient progress. Chart notes. Review patient management with nursing staff. Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function. Monitor incision for signs of infection or hematoma. Assess facial nerve function. Answer patient and family questions. Answer nursing staff questions. Discuss patient progress with referring physician. Assure adequate level of pain control. Monitor drain, remove prior to discharge if appropriate. Chart discharge instructions. Write prescriptions for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations with patient and family. Dictate discharge summary. Perform medication reconciliation. Office: Examine patient, remove sutures. Monitor output and remove drain if not removed prior to discharge. Answer patient and family questions. Review pathology report. Monitor facial nerve functional deficits, if any. Assess for adequacy of pain control. Discuss advancing daily activities with patient. Discuss long term scar management with patient. Discuss pathology report with patient and need for any additional testing or consultation. Arrange for any indicated additional testing and review results. Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants, review reports from consultants. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Jane Dillon, MD; Christopher Senkowski, MD, FACS				
Specialty(s):	otolaryngology; general surgery				
CPT Code:	42415				
Sample Size: 250	**Resp N:** 76	**Response:** 30.4 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	2.00	10.00	**14.00**	20.00	60.00
Survey RVW:	12.00	18.00	**20.00**	22.13	35.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	90.00	120.00	**150.00**	150.00	250.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	42415	**Recommended Physician Work RVU: 17.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
60271	090	17.54	**RUC Time**

CPT Descriptor Thyroidectomy, including substernal thyroid; cervical 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	Work RVU	Time Source	Most Recent Medicare Utilization
22554	090	17.54	**RUC Time**	27,718

CPT Descriptor 1 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34203	090	17.73	**RUC Time**	2,707

CPT Descriptor 2 Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision

Other Reference CPT Code	Global	Work RVU	Time Source
60260	090	18.18	**RUC Time**

CPT Descriptor Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 27.6 %

TIME ESTIMATES (Median)	CPT Code: 42415	Key Reference CPT Code: 60271	Source of Time RUC Time
Median Pre-Service Time	72.00	60.00	
Median Intra-Service Time	150.00	150.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**342.00**	**377.00**	

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	3.19	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.14
Urgency of medical decision making	2.86	2.81

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	4.10
Physical effort required	3.71	3.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.05	3.62
Outcome depends on the skill and judgment of physician	4.24	4.05
Estimated risk of malpractice suit with poor outcome	4.67	4.24

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.05
Intra-Service intensity/complexity	4.10	3.85
Post-Service intensity/complexity	2.57	2.65

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 Va Recommendations for the appropriate formula and format.*

Pre-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change.

- Positioning: Add 9 minutes - After induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head rotated and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed.
- Scrub/Dress/Wait: no change

In comparison to the reference code 60271, the pre-service work for 42415 requires more time to review the planned procedure and the risks, including a detailed discussion of possible facial nerve paralysis (paresis is common), which may result in functional speech, mastication, and eye closure issues, as well as facial disfigurement; facial numbness and change in appearance at operative site (both of which always happen); facial scarring and possible need for revision, late sequelae including Frye's syndrome and tumor recurrence – an important issue even with benign tumors.

The intra-service time for 42415 and the reference code 60271 is the same (150 min), however, the intra-service intensity and complexity of 42415 is greater as seen in the survey mean intra-service intensity/complexity and all mean measures of technical skill and psychological stress statistics. The facial nerve is at risk during almost all parts of the procedure, including possible damage during flap raising, localization of main trunk, and dissection of peripheral branches, making this a high intensity procedure throughout. The nerve buried in the middle of the parotid gland, which is dense, fibrous, and vascular is difficult to find, difficult to dissect, easy to injure – even with gentle traction or nerve stimulation. Facial nerve injury results in significant functional issues related to speech, mastication, and eye closure as well as facial disfigurement. For the reference code, nerve dissection is more limited, and separating the nerve from the gland is less prone to injury. Unlike the thyroid (60271), even benign tumors of the parotid are prone to recurrence, requiring more attention to wide margins, and meticulous handling to prevent tumor cell seeding of the operative site. The survey data indicate a majority of patients are treated in the hospital and a majority will stay at least overnight. The typical patient will require monitoring for hematoma formation and facial nerve function, control pain and nausea, maintenance of hydration with IV fluids. The next day, the surgeon will change dressing, assess facial nerve function and prescribe indicated treatment for deficits, particularly related to eye closure. The wound and drain are assessed. If the patient is stable, he/she will be discharged.

Office work for 42415 is greater than the reference code. An additional office visit 1-2 days after discharge is necessary because patients undergoing 42145 typically go home with a drain (unlike thyroid). At all office visits, facial nerve function and counseling is important.

A Harvard-based code is not a RUC compelling evidence standard. Consequently, we are not asking the RUC for consideration of a change to the RVW for 42415. However, we would like to reserve the option to review this code at a later time, if Harvard-based becomes a compelling evidence standard. The discussion above which compares 42415 to the reference code supports maintaining the current value of 17.99 RVUs for 42415. As additional justification, we also offer two MPC codes (22554 and 34203) with similar RVWs, significantly less intra-op time, but greater hospital work. Another comparison code that is not an MPC code but is similar in terms of anatomy is 60260 with a slightly higher RVW (18.18) and more hospital work, but less office work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 42415

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty otolaryngology How often? Sometimes

Specialty general surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national frequency unavailable

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
4,636 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. RUC database 2006 utilization

Specialty otolaryngology Frequency 4219 Percentage 91.00 %

Specialty general surgery Frequency 197 Percentage 4.24 %

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. Maintain PLI for current code 42415

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:42420 Tracking Number Specialty Society Recommended RVU: **20.87**

Global Period: 090 RUC Recommended RVU: **20.87**

CPT Descriptor: Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old man presents with a 12-month history of a 1.5 centimeter left preauricular mass. Over the past 3 months, he has had increasing pain but has no evidence of facial nerve weakness. There is no palpable cervical adenopathy. An MRI shows a mass with irregular borders, in the deep lobe of the parotid gland. There is no adenopathy noted on the scan. A fine needle biopsy reveals squamous cell carcinoma. The patient undergoes a total parotidectomy with dissection and preservation of the facial nerve.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 3% , Kept overnight (less than 24 hours) 36% , Admitted (more than 24 hours) 62%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 56%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review medical history, pathology, and radiology report. Review radiographic images. Review results of preoperative testing (labs, EKG, CXR). Review reports of consultants providing preoperative assessment and clearance as indicated. Meet with patient and family to review planned procedure and postoperative management. Reexamine patient to ensure that physical findings have not changed and dictate history and physical. Obtain informed consent. Review hospital consent, mark patient. Review airway and medical management with anesthesiologist. Review planned procedure with OR staff. Verify that all required instruments and supplies are available. Change into scrub clothes. Monitor/assist with positioning of the patient. Ensure that radiographic images are available in the OR. Mark planned incision. Inject planned incision with vasoconstrictor. Monitor/assist with prepping and draping. Scrub and gown. Perform surgical "time out" with operating surgical team.Place facial nerve monitor.

escription of Intra-Service Work: Under anesthesia, a preauricular incision is made with curved cervical extension below the angle of the mandible. Anterior and posterior skin flaps are elevated in the subplatysmal plane, superficial to the parotid fascia, exposing the parotid gland and the sternocleidomastoid muscle. The parotid gland is dissected from the anterior border of the sternocleidomastoid muscle and the greater auricular nerve is transected. The gland is dissected from the mastoid process and the cartilage of the external auditory canal. The main trunk of the facial nerve is

identified and protected. Facial nerve stimulation is performed as needed at various points during the procedure. The overlying parotid tissue is elevated from the main trunk of the facial nerve to expose the bifurcation. The peripheral branches of the facial nerve are sequentially dissected, separating the overlying parotid tissue from the facial nerve and deep lobe of the gland. The facial nerve is mobilized and gently retracted. The lobe and associated tissue are remo and sent to pathology. All structures are inspected including the facial nerve. A deep drain is placed and the wc closed in layers.

Description of Post-Service Work: Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure proper drain function and assess facial nerve function. Write postoperative note. Dictate operative note and copy to referring physician. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Examine patient, check wound and patient progress - Monitor closely for airway patency and for development of cervical hematoma. Write orders for postoperative medications, diet, and patient activity. Check wounds, change dressings, and monitor patient progress. Chart notes. Review patient management with nursing staff. Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function. Monitor incision for signs of infection or hematoma. Assess facial nerve function. Answer patient and family questions. Answer nursing staff questions. Discuss patient progress with referring physician. Assure adequate level of pain control. Monitor drain, remove prior to discharge if appropriate. Chart discharge instructions. Write prescriptions for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations with patient and family. Dictate discharge summary. Perform medication reconciliation.

Office: Examine patient, remove sutures. Monitor output and remove drain if not removed prior to discharge. Answer patient and family questions. Review pathology report. Monitor facial nerve functional deficits, if any. Assess for adequacy of pain control. Discuss advancing daily activities with patient. Discuss long term scar management with patient. Discuss pathology report with patient and need for any additional testing or consultation. Arrange for any indicated additional testing and review results. Arrange for any indicated consultation, prepare documents fo transmission to appropriate consultants, review reports from consultants. Discuss progress with referring physiciar (verbal and written). Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Jane Dillon, MD; Christopher Senkowski, MD, FACS					
pecialty(s):	otolaryngology; general surgery					
CPT Code:	42420					
Sample Size:	250	**Resp N:**	76	**Response:** 30.4 %		
Sample Type:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	7.00	25.00
Survey RVW:	8.00	23.36	**25.00**	30.50	45.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	115.00	158.00	**180.00**	240.00	350.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	42420	**Recommended Physician Work RVU: 20.87**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **1.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
ffice time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
38724	090	23.72	**RUC Time**

CPT Descriptor Cervical lymphadenectomy (modified radical neck dissection)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35656	090	20.39	**RUC Time**	14,026

CPT Descriptor 1 Bypass graft, with other than vein; femoral-popliteal

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35141	090	20.83	**RUC Time**	3,709

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 femoris, superficial femoral)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 30.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 42420**	**Key Reference CPT Code: 38724**	**Source of Time RUC Time**
Median Pre-Service Time	72.00	75.00	
Median Intra-Service Time	180.00	180.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	109.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**432.00**	**512.00**	
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	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.87
Urgency of medical decision making	4.22	4.26

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.57
Physical effort required	4.39	4.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.83	4.43
Outcome depends on the skill and judgment of physician	4.74	4.30
Estimated risk of malpractice suit with poor outcome	4.74	4.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.13	4.04
Intra-Service intensity/complexity	4.74	4.52
Post-Service intensity/complexity	3.39	3.57

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.*

re-Time: With respect to the pre-service time, we recommend package 4 with the following modifications:

- Evaluation: no change.
- Positioning: Add 9 minutes - After induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head rotated and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed.

- Scrub/Dress/Wait: no change

For both the survey code and reference code, the risk of nerve dysfunction, functional and cosmetic issues are significant. The intra-service time for 42420 and the reference code 38724 is the same (180 min), however, the intra-service intensity and complexity of 42420 is greater as seen in the survey mean intra-service intensity/complexity and all mean measures of technical skill and psychological stress statistics. The facial nerve is at risk during almost all parts of the procedure, including possible damage during flap raising, localization of main trunk, and dissection of peripheral branches, making this a high intensity procedure throughout. The nerve buried in the middle of the parotid gland, which is dense, fibrous, and vascular is difficult to find, difficult to dissect, easy to injure - even with gentle traction or nerve stimulation. 42420 involves dissecting the nerve away from not only the superficial lobe, but on the underside from the deep lobe, with increased risk of injury. Deep lobe tumors are often malignant, resulting in increased technical difficulty to dissect the nerve free and more complex intraoperative decision-making regarding nerve preservation. Facial nerve injury results in significant functional issues related to speech, mastication, and eye closure as well as facial disfigurement. With 38724, nerve dissection is more limited, and nerves are less prone to injury. Similar to 38724, tumors of the parotid are prone to recurrence, requiring attention to wide margins, and meticulous handling to prevent tumor cell seeding of the operative site.

The survey data indicate and we concur that these patients are typically admitted to the hospital and will remain for several days. Monitoring for airway patency, hematoma formation, facial nerve function and intervention for any noted deficits, drain function, and control of pain and nausea is necessary. Patients are maintained on IV fluids until oral intake is possible. The patient will go home with the drain in place and require a visit 1-2 days after discharge for drain removal if appropriate.

A Harvard-based code is not a RUC compelling evidence standard. Consequently, we are not asking the RUC for consideration of a change to the RVW for 42420. However, we would like to reserve the option to review this code at a later time, if Harvard-based becomes a compelling evidence standard. The discussion above which compares 42420 to the reference code supports maintaining the current value of 20.87 RVUs for 42420. As additional justification, we also offer two MPC codes (35656 and 35141) with similar RVWs and similar total time (less intra-time, more hospital work, and less office work). Another comparison code that is not an MPC code but is similar in terms of anatomy is 60252 with a slightly higher RVW (21.88), the same intra-op time, but slightly more post-op work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 42420

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty otolaryngology How often? Sometimes

Specialty general surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. national frequency unavailable

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?
1,590 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. RUC database 2006 frequency

Specialty otolaryngology Frequency 1475 Percentage 92.76 %

Specialty general surgery Frequency 45 Percentage 2.83 %

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. Maintain PLI for current code 42420

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

			Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings								Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings								Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214		Current Intra Time	Change in Intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time		99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1			60	0	L037D			4	0		0				-1	1		Yes	9
28120	50	50	1	0	3	2	0		67	-17	L037D	1	0	3.5	0	0	-17		0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0		51	-6	L037D	1	0	5	0	0	-6		0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0		60	30	L037D	1	0	4	0	0	0		0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0		120	-20	L037D	1	0	0	5	0	0		0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0		81	39	L037D	1	0	2.5	0	0	0		0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0		156	-6	L037D	1	0	0	3.5	0	0		0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0		182	-2	L037D	1	0	0	3.5	0	0		0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0		67.5	2.5	L037D	1	0	1	1	0	0		0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0		90	0	L037D	1	0	1	1	0	0		0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0		60	0	L037D	1	0	1	1	0	0		0	0	0	0	0	No	0
69100	12	8							10	2	L037D						1							No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Hernia Repair

CPT codes 49507, *Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated*, 49521, *Repair recurrent inguinal hernia, any age; incarcerated or strangulated*, and 49587, *Repair umbilical hernia, age 5 years or older; incarcerated or strangulated* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

1804

49507

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49507. However, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 98% of respondents perform the procedure in the hospital. Of those 98%, 83% stay overnight, and of those 83%, 73% (or 59% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 70 minutes and immediate post-service time of 30 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day

management service, and one 99212 and one 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49507 to the key reference service 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88 intra-time = 70 minutes). The RUC also compared 49507 to 54512, Excision of extraparenchymal lesion of testis (work RVU = 9.22, pre-time = 50 minutes, intra-time = 70 minutes, post-service = 30) and noted that there is more pre-service time in the surveyed code (63 versus 50 minutes) accounting for the slight difference in work RVU. The RUC noted that the reference service contains less pre-service and immediate post-service and is less intense than the surveyed code. The RUC also noted that the 25th percentile survey work RVU was 9.91 and the median work RVU was 11.00. **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 9.97 for CPT code 49507.**

49521

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49521. However, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 99% of respondents perform the procedure in the hospital. Of those 99%, 82% stay overnight, and of those 82%, 68% (or 55% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes. During the immediate post-service work, the physician protects the wound with a hand while the patient comes out of anesthesia so that an unrestrained cough does not disrupt the repair. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49521 to the key reference service, 49520, *Repair recurrent inguinal hernia, any age; reducible*, (work RVU = 9.91, intra-service time = 60 minutes). The RUC noted that it contained 30 minutes less intra-service time and requires less intensity and complexity that the surveyed code. The RUC also compared 49521 to 49652, *Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* (work RVU = 12.80, pre-time = 75, intra-time = 90, immediate post-time = 30) and noted that the two codes are similar and have identical intra- and immediate post-service time, but that the reference code has slightly more pre-service time accounting for the difference in work RVU. The RUC also noted that the survey

respondents indicated a median work RVU of 14.00 and a 25th percentile work RVU of 11.00. **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 12.36 for CPT code 49521.**

49587

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49587. However, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 100% of respondents perform the procedure in the hospital. Of those, 71% stay overnight, and of those 71%, 77% (or 55% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 60 minutes and immediate post-service time of 30 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49587 to the key reference service, 49585, *Repair umbilical hernia, age 5 years or older; reducible*, (work RVU = 6.51, intra-service time = 45 minutes). The RUC noted that the reference service requires 15 fewer minutes and requires less intensity and complexity than the surveyed code. The RUC also compared 49587 to 49572, *Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated* (work RVU = 7.79, pre-time = 45 intra-time = 60, immediate post-time = 30). The RUC agreed that the two codes are similar, but that the difference in intra-service accounts for the slight difference in work RVUs. The RUC also noted that the survey respondents indicated a median work RVU of 11.50 work RVUs. **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 7.96 for CPT code 49587.**

1806

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	090	9.97 (No Change)
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	090	12.36 (No Change)
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	090	7.96 (No Change)

1807

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49507 Tracking Number Specialty Society Recommended RVU: **9.97**

Global Period: 090 RUC Recommended RVU: **9.97**

CPT Descriptor: Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with 2 hour history of painful swelling in the left groin. Physical exam reveals an inguinal hernia that is tender and nonreducible by manual manipulation. He undergoes operative reduction and repair.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 2%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 17% , Kept overnight (less than 24 hours) 40% , Admitted (more than 24 hours) 43%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 73%

.s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possiblity of bowel resection, with 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. Install or supervise installation of Foley catheter 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: Incision is made through skin and subcutaneous tissue taking care not to injure the nderlying bowel that is incarcerated. Dissection carried out meticulously around the hernia sac to expose the external .scial ring. Incision is then made in the external oblique fascia taking care to preserve the ilioinguinal nerve. Flaps of the external oblique fascia are made to expose underside of Poupart's ligament laterally and the internal oblique muscle medially. The defect whether direct or indirect is then determined in relation to epigastric vessels and the transversalis fascia. The neck of the hernia sac is then released to allow pressure on the hernia sac contents to be lessened. The vas deferens and spermatic vessels are carefully dissected from the hernia sac. The hernia sac is then opened to facilitate

examination of the incarcerated hernia sac contents. The viability of the bowel is assessed. If bowel resection is indicated, it is performed (reported separately). If no resection is required, the bowel is meticulously inspected, allowed to partially reduce and reinspected to ensure that it is likely viable. The operative site is then assessed to determine ability to place mesh and the potential infection risk. Once the bowel is reduced, the peritoneum of the hernia sac circumferentially dissected (or resected if there is excess) and oversewn. The cord structures are carefully dissected retracted to prevent injury to the Vas Deferens and vessels. The inguinal ligament, inguinal floor and conjoined tendon are defined. Mesh is placed either to plug the defect or as an onlay patch or a combination. The mesh is sutured in place to Poupart ligament and the medial conjoined tendon. A new internal ring is created as mesh encircles the spermatic vessels and vas deferens taking care to not compromise the structures to prevent injury or necrosis. Finally the mesh is placed under the internal oblique muscle to prevent recurrence. Hemostasis is obtained. The external oblique fascia is reapproximated with care to avoid ilioinguinal nerve injury, entrapment, and significant chronic pain. The wound is irrigated. The Scarpa's fascia is reapproximated and the skin is closed. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work: Hospital: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. 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 including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. 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. Monitor and document patient progress. 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 & family questions. Answer nursing/other staff questions. Advance diet, as appropriate. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (i.e., diet, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when there is return of bowel function, taking adequate nutrition, 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.

At follow-up office visits: Examine and talk with patient. Remove staples or sutures, when appropriate. Review activity and restrictions. Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	general surgery				
CPT Code:	49507				
Sample Size:	300	**Resp N:**	84	**Response:** 28.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	10.00	50.00
Survey RVW:	7.88	9.91	**11.00**	14.25	25.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**70.00**	86.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49507	**Recommended Physician Work RVU: 9.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
49505	090	7.88	RUC Time

CPT Descriptor Repair initial inguinal hernia, age 5 years or older; reducible

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 23.8 %

TIME ESTIMATES (Median)

	CPT Code: 49507	Key Reference CPT Code: 49505	Source of Time RUC Time
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	70.00	70.00	
Median Immediate Post-service Time	30.00	20.00	
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	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**260.00**	**198.00**	
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	2.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.40	2.10
Urgency of medical decision making	3.20	2.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.05	2.65
Physical effort required	2.65	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.90	2.20
Outcome depends on the skill and judgment of physician	3.20	2.75
Estimated risk of malpractice suit with poor outcome	3.10	2.70

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.95	2.35
Intra-Service intensity/complexity	3.00	2.45
Post-Service intensity/complexity	2.40	2.10

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.*

Coding changes were made to the family of hernia codes for CPT 1994 to differentiate physician work. A request was made to separate incarcerated and strangulated hernias, but the CPT Editorial Panel chose to combine those procedures. The RUC process in 1993 utilized consistent ratios for valuing reducible, incarcerated/strangulated, initial, and recurrent for each type of hernia, with a goal of maintaining budget neutrality across all hernia codes. In 2000, during the 2nd 5 year review, the hernia codes were surveyed as minisurveys (except for 49505) and the work RVUs adjusted using the

percentage change made to 49505, which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the mini-surveys were not reviewed on a code-by-code basis.

For code 49507, the 2006 Medicare claims data in the RUC database indicate 48% inpatient hospital and 48% outpatient hospital. The 2007 Medicare claims data show a slight change to 46% inpatient and 48% outpatient, along with a slight decrease in total frequency. Our current survey indicates a close split between hospital admit and overnight. For the respondents that indicated an overnight stay, a majority indicated an E/M service would be performed on the same day (73%).

The survey data show - and our expert consensus panel concurs - that a majority of these patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Clearly, if on the day of surgery, the surgeon's orders are to admit the patient, follow-up hospital E/M visit(s) that occur should be considered part of the typical global work. This is independent of whether the post-discharge "billing status" for a patient changes from admit to outpatient the next day because the patient is discharged "within" 24 hours.

We believe that semantics about place of service and length of stay have created an undo concern with regard to screening, reviewing and accounting for physician work. Medicare representatives have stated that a claim designated as "outpatient" is a hospital stay of 23hr-59min or less. On the other hand, CPT codes describe E/M codes in a less concrete fashion. For example, codes 99201-99205 and 99211-99215 describe E/M services provided in the physician's office or in an outpatient or other ambulatory facility. These place of service designations are not consistent with patients staying overnight or longer on a hospital surgical ward. We would argue that a hospital surgical ward is not "ambulatory." Further, CPT indicates that codes 99234-99236 are to be used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. For these codes, claims can correctly be submitted as inpatient same day service and in 2006, Medicare claims data show more than 50% inpatient claims for 99234. Clearly, 50%+ of these 71,000+ patients were not admitted at 12:00am and discharged at midnight – which according to Medicare is the only way that a claim can be considered inpatient.

All of the discussion above is meant to emphasize that reason needs to prevail in the discussion about accounting for physician work for patients who are not ambulatory and do not leave a hospital outpatient surgery center on the day of a procedure, but instead are admitted to the surgical ward. A claim's place of service designation does not relate to or accurately describe physician work. If 50% of claims for same day E/M work can have a place of service designation as inpatient, then some percentage of claims with a place of service designation of outpatient can be patients staying overnight (or longer). Discussion of clinical rationale and professional judgment is important to the review process – not just a claim's place of service designation.

The site of service screen used for 49507 inaccurately portrays these patients as typically ambulatory and leaving a facility on the same date of service. OPPS data for this code includes claims where patients were admitted and discharged on different dates. The current RUC survey indicates that the typical patient is admitted or kept overnight and that an E/M visit is performed on the day of the procedure. An expert panel of general surgeons representing all geographic practice settings and all types of practices have reviewed the survey data for this code and believe that the clinical rationale discussed above justifies admitting a majority of these patients. **We recommend maintaining the current work RVU of 9.97. We also recommend the survey median time and visits which include E/M work on the day of the procedure and 1 x 99238 for the discharge work provided the next day, if the patient can safely be released from the hospital.**

With respect to the E/M work on the day of the procedure, we believe the typical service is equivalent to 99231 because the typical patient is admitted to the surgical ward by the surgeon's orders and until the patient is discharged, the work being performed is inpatient. However, if semantics require use of different codes, then we might suggest using the following two codes as proxies: 99218 *Observation care* for work on the day of the procedure and 99217 *Observation care discharge* for work the following day. The use of these proxies will require a change to the SoR and the RUC database because these codes are not currently identified. However, we do not suggest adding these codes – which would only be proxies for work – to the RUC 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49507

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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency unknown, but typical patient is not Medicare aged.

Specialty general surgery Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
12,147 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare database

Specialty general surgery Frequency 11078 Percentage 91.19 %

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? No

If no, please select another crosswalk and provide a brief rationale. Use current code 49507

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:49521 Tracking Number Specialty Society Recommended RVU: **12.36**

Global Period: 090 RUC Recommended RVU: **12.36**

CPT Descriptor: Repair recurrent inguinal hernia, any age; incarcerated or strangulated

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with a history of right inguinal hernia repair with mesh five years ago, now presents with a progressive history of painful swelling in the right groin. Physical exam reveals an inguinal mass that is tender and nonreducible by manual manipulation. He undergoes operative reduction and repair.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Percent of survey respondents who stated they perform the procedure; In the hospital 99% , In the ASC 1%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 18% , Kept overnight (less than 24 hours) 37% , Admitted (more than 24 hours) 45%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 68%

.s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possiblity of bowel resection, with 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. Install or supervise installation of Foley catheter 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: Incision is made through previous skin scar and subcutaneous tissue taking care not injure the underlying bowel that is incarcerated. Dissection carried out meticulously around the hernia sac to expose .e external fascial ring. Lateral landmarks for inguinal ligament are identified to provide orientation in the reoperative field. Incision is then made in the previously incised external oblique fascia taking care to preserve the ilioinguinal nerve. Flaps of the external oblique fascia through the scar tissue are made to expose the underside of Poupart's ligament laterally and the internal oblique muscle medially. The previous mesh and inherent adhesive reaction are assessed in order to define the hernia defect and the spermatic cord. The defect is then defined in relation to epigastric

vessels and the transversalis fascia. The scar tissue around the neck of the hernia sac is then released to allow pressure on the hernia sac contents to be lessened. The vas deferens and spermatic vessels are carefully dissected from the hernia sac. The hernia sac is then opened to facilitate examination of the incarcerated hernia sac contents. The viability of the bowel is then assessed. If bowel resection is indicated, it is performed (reported separately). If no resection is requir the bowel is reduced into the abdomen and the degree of ischemia is assessed to determine ability to place mesh and potential infection risk. The old mesh is not removed as it is normally intensely incorporated into the tissue. Once the bowel is reduced, the peritoneum of the hernia sac is circumferentially dissected, resected if there is excess and oversewn. The cord structures are carefully dissected and retracted to prevent injury to the Vas Deferens and vessels. The inguinal ligament, inguinal floor and conjoined tendon are defined. Mesh is placed either to plug defect or as an onlay patch or a combination. The mesh is sutured in place to the defect. A new internal ring is created as mesh encircles the spermatic vessels and vas deferens taking care to not compromise the structures to prevent injury or necrosis. Finally the mesh is placed under the internal oblique muscle to prevent against recurrence. Hemostasis is obtained. The external oblique fascia is reapproximated with care to avoid ilioinguinal nerve injury, entrapment, and significant chronic pain. The wound is irrigated. The Scarpa's fascia is reapproximated and the skin is closed. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work: Hospital: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. 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 including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy as appropriate. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. 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. Monitor and document patient progress. Asse pain scores and adequacy of analgesia. Monitor fluid and electrolyte status and renal function. Review nursing/othe 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. Advance diet, as appropriate. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity (i.e., diet, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when there is return of bowel function, taking adequate nutrition, 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.

At follow-up office visits: Examine and talk with patient. Remove staples or sutures, when appropriate. Review activity and restrictions. Monitor healing of incision with appropriate physical examination, including dealing with questions of patient and family. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	general surgery				
CPT Code:	49521				
Sample Size:	300	**Resp N:**	84	**Response:** 28.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	5.00	50.00
Survey RVW:	9.00	11.00	**14.00**	16.05	27.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**90.00**	96.00	150.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49521	**Recommended Physician Work RVU: 12.36**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
49520	090	9.91	**RUC Time**

CPT Descriptor Repair recurrent inguinal hernia, any age; reducible

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 27.3 %

TIME ESTIMATES (Median)	CPT Code: 49521	Key Reference CPT Code: 49520	Source of Time RUC Time
Median Pre-Service Time	63.00	45.00	
Median Intra-Service Time	90.00	60.00	
Median Immediate Post-service Time	30.00	23.00	
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	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**280.00**	**186.00**	
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	2.91	2.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.48
Urgency of medical decision making	3.48	2.52
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.57	3.04
Physical effort required	2.96	2.78
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.52	2.65
Outcome depends on the skill and judgment of physician	3.52	3.04
Estimated risk of malpractice suit with poor outcome	3.30	2.91

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.70
Intra-Service intensity/complexity	3.74	3.00
Post-Service intensity/complexity	2.61	2.30

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.*

Coding changes were made to the family of hernia codes for CPT 1994 to differentiate physician work. A request was made to separate incarcerated and strangulated hernias, but the CPT Editorial Panel chose to combine those procedures. The RUC process in 1993 utilized consistent ratios for valuing reducible, incarcerated/strangulated, initial, and recurrent for each type of hernia, with a goal of maintaining budget neutrality across all hernia codes. In 2000, during the 2nd 5 year review, the hernia codes were surveyed as mini surveys (except for 49505) and the work RVUs adjusted using the

percentage change made to 49505, which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the mini-surveys were not reviewed on a code-by-code basis.

For code 49521, the 2006 Medicare claims data in the RUC database indicate 43% inpatient hospital and 52% outpatient hospital. The 2007 Medicare claims data show a change to **greater** inpatient 46% and less outpatient 49%, along with a slight decrease in total frequency. Our current survey indicates a greater frequency of hospital admit than overnight (45% vs 37%). For the respondents that indicated an overnight stay, a majority indicated an E/M service would be performed on the same day (68%).

The survey data show - and our expert consensus panel concurs - that a majority of these patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring for problems such as ileus, ischemia, and urinary retention. Additionally, there will be severe pain post-operatively requiring management before discharge. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Clearly, if on the day of surgery, the surgeon's orders are to admit the patient, follow-up hospital E/M visit(s) that occur should be considered part of the typical global work. This is independent of whether the post-discharge "billing status" for a patient changes from admit to outpatient the next day because the patient is discharged "within" 24 hours.

We believe that semantics about place of service and length of stay have created an undo concern with regard to screening, reviewing and accounting for physician work. Medicare representatives have stated that a claim designated as "outpatient" is a hospital stay of 23hr-59min or less. On the other hand, CPT codes describe E/M codes in a less concrete fashion. For example, codes 99201-99205 and 99211-99215 describe E/M services provided in the physician's office or in an outpatient or other ambulatory facility. These place of service designations are not consistent with patients staying overnight or longer on a hospital surgical ward. We would argue that a hospital surgical ward is not "ambulatory." Further, CPT indicates that codes 99234-99236 are to be used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. For these codes, claims can correctly be submitted as inpatient same day service and in 2006, Medicare claims data show more than 50% inpatient claims for 99234. Clearly, 50%+ of these 71,000+ patients were not admitted at 12:00am and discharged at midnight – which according to Medicare is the only way that a claim can be considered inpatient.

All of the discussion above is meant to emphasize that reason needs to prevail in the discussion about accounting for physician work for patients who are not ambulatory and do not leave a hospital outpatient surgery center on the day of a procedure, but instead are admitted to the surgical ward. A claim's place of service designation does not relate to or accurately describe physician work. If 50% of claims for same day E/M work can have a place of service designation as inpatient, then some percentage of claims with a place of service designation of outpatient can be patients staying overnight (or longer). Discussion of clinical rationale and professional judgment is important to the review process – not just a claim's place of service designation.

The site of service screen used for 49521 inaccurately portrays these patients as typically ambulatory and leaving a facility on the same date of service. OPPS data for this code includes claims where patients were admitted and discharged on different dates. The current RUC survey indicates that the typical patient is admitted or kept overnight and that an E/M visit is performed on the day of the procedure. An expert panel of general surgeons representing all geographic practice settings and all types of practices have reviewed the survey data for this code and believe that the clinical rationale discussed above justifies admitting a majority of these patients. **We recommend maintaining the current work RVU of 12.36. We also recommend the survey median time and visits which include E/M work on the day of the procedure and 1 x 99238 for the discharge work provided the next day, if the patient can safely be released from the hospital.**

With respect to the E/M work on the day of the procedure, we believe the typical service is equivalent to 99231 because the typical patient is admitted to the surgical ward by the surgeon's orders and until the patient is discharged, the work being performed is inpatient. However, if semantics require use of different codes, then we might suggest using the followi two codes as proxies: 99218 *Observation care* for work on the day of the procedure and 99217 *Observation care dischar* for work the following day. The use of these proxies will require a change to the SoR and the RUC database because these codes are not currently identified. However, we do not suggest adding these codes – which would only be proxies for work – to the RUC 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49521

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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency unknown, but typical patient is not Medicare aged.

Specialty general surgery 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?
3,062 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2006 Medicare database

Specialty general surgery Frequency 2783 Percentage 90.88 %

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? No

If no, please select another crosswalk and provide a brief rationale. Use current code 49521

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:49587 Tracking Number Specialty Society Recommended RVU: **7.96**

Global Period: 090 RUC Recommended RVU: **7.96**

CPT Descriptor: Repair umbilical hernia, age 5 years or over; incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male presents with 3 hour history of painful swelling in the umbilical region. Physical exam reveals an umbilical hernia that is tender and nonreducible by manual manipulation. He undergoes operative reduction and repair.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 30% , Kept overnight (less than 24 hours) 42% , Admitted (more than 24 hours) 29%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 77%

s moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possiblity of bowel resection, with 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. Install or supervise installation of Foley catheter 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: Incision is made through skin and subcutaneous tissue taking care not to injure the derlying bowel that is incarcerated. Dissection carried out meticulously around the hernia sac to expose the fascial g. The neck of the hernia sac is then released to allow pressure on the hernia sac contents to be lessened. The hernia sac is opened to facilitate examination of the incarcerated contents. The viability of the bowel is assessed. If bowel resection is indicated, it is performed (reported separately). If no resection is required, the bowel is reduced into the abdomen and the degree of ischemia is assessed to determine ability to place mesh and the potential risk for infection. Once the bowel is reduced, the peritoneum of the hernia sac is circumferentially dissected, resected if there is excess and

oversewn. The fascial defect is closed either primarily or with added implantation of mesh (reported separately) as determined by the size of the defect and the quality of the fascia. Hemostasis is obtained. The wound is irrigated. The subcutaneous tissue is reapproximated and the skin is closed. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work: Hospital: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. 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 including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy as appropriate. Instruct nursing staff in care of tubes and other devices. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses. 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. Monitor and document patient progress. 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. Advance diet, as appropriate. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when there is return of bowel function, taking adequate nutrition, 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.

At follow-up office visits: Examine and talk with patient. Remove staples or sutures, when appropriate. Review activity and restrictions. Monitor healing of incision with appropriate physical examination, including dealing w questions of patient and family. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Arrange to return for review if necessary. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009					
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS					
pecialty(s):	general surgery					
CPT Code:	49587					
Sample Size:	300	**Resp N:**	84	**Response:** 28.0 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	3.00	**5.00**	8.00	60.00	
Survey RVW:	7.00	10.00	**11.50**	13.55	19.00	
Pre-Service Evaluation Time:			**60.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	30.00	45.00	**60.00**	80.00	150.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
rolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49587	**Recommended Physician Work RVU: 7.96**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**60.00**		
Immediate Post Service-Time:	**30.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0**		
ffice time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

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
49585	090	6.51	**RUC Time**

CPT Descriptor Repair umbilical hernia, age 5 years or older; reducible

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 23.8 %

TIME ESTIMATES (Median)	CPT Code: 49587	Key Reference CPT Code: 49585	Source of Time RUC Time
Median Pre-Service Time	63.00	45.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	20.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**250.00**	**178.00**	
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	2.65	2.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.35
Urgency of medical decision making	3.50	2.65

Technical Skill/Physical Effort (Mean)

Technical skill required	3.15	2.90
Physical effort required	2.85	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.25	2.70
Outcome depends on the skill and judgment of physician	3.35	3.00
Estimated risk of malpractice suit with poor outcome	3.35	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.25	2.70
Intra-Service intensity/complexity	3.25	2.70
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.*

Coding changes were made to the family of hernia codes for CPT 1994 to differentiate physician work. A request was made to separate incarcerated and strangulated hernias, but the CPT Editorial Panel chose to combine those procedures. The RUC process in 1993 utilized consistent ratios for valuing reducible, incarcerated/strangulated, initial, and recurrent for each type of hernia, with a goal of maintaining budget neutrality across all hernia codes. In 2000, during the 2nd 5 year review, the hernia codes were surveyed as minisurveys (except for 49505) and the work RVUs adjusted using the

percentage change made to 49505, which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the mini-surveys were not reviewed on a code-by-code basis.

For code 49587, the 2006 Medicare claims data in the RUC database indicate 37% inpatient hospital and 56% outpatient hospital. The 2007 Medicare claims data show a slight change to 36% inpatient and 56% outpatient, along with a 5% decrease in total frequency. Our current survey indicates a majority of the patients are kept overnight. For the respondents that indicated an overnight stay, a majority indicated an E/M service would be performed on the same day (77%).

The survey data show - and our expert consensus panel concurs - that a majority of these patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring for problems such as ileus, ischemia, and urinary retention. Additionally, there will be severe pain post-operatively requiring management before discharge. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Clearly, if on the day of surgery, the surgeon's orders are to admit the patient, follow-up hospital E/M visit(s) that occur should be considered part of the typical global work. This is independent of whether the post-discharge "billing status" for a patient changes from admit to outpatient the next day because the patient is discharged "within" 24 hours.

We believe that semantics about place of service and length of stay have created an undo concern with regard to screening, reviewing and accounting for physician work. Medicare representatives have stated that a claim designated as "outpatient" is a hospital stay of 23hr-59min or less. On the other hand, CPT codes describe E/M codes in a less concrete fashion. For example, codes 99201-99205 and 99211-99215 describe E/M services provided in the physician's office or in an outpatient or other ambulatory facility. These place of service designations are not consistent with patients staying overnight or longer on a hospital surgical ward. We would argue that a hospital surgical ward is not "ambulatory." Further, CPT indicates that codes 99234-99236 are to be used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. For these codes, claims can correctly be submitted as inpatient same day service and in 2006, Medicare claims data show more than 50% inpatient claims for 99234. Clearly, 50%+ of these 71,000+ patients were not admitted at 12:00am and discharged at midnight – which according to Medicare is the only way that a claim can be considered inpatient.

All of the discussion above is meant to emphasize that reason needs to prevail in the discussion about accounting for physician work for patients who are not ambulatory and do not leave a hospital outpatient surgery center on the day of a procedure, but instead are admitted to the surgical ward. A claim's place of service designation does not relate to or accurately describe physician work. If 50% of claims for same day E/M work can have a place of service designation as inpatient, then some percentage of claims with a place of service designation of outpatient can be patients staying overnight (or longer). Discussion of clinical rationale and professional judgment is important to the review process – not just a claim's place of service designation.

The site of service screen used for 49587 inaccurately portrays these patients as typically ambulatory and leaving a facility on the same date of service. OPPS data for this code includes claims where patients were admitted and discharged on different dates. The current RUC survey indicates that the typical patient is admitted or kept overnight and that an E/M visit is performed on the day of the procedure. An expert panel of general surgeons representing all geographic practice settings and all types of practices have reviewed the survey data for this code and believe that the clinical rationale discussed above justifies admitting a majority of these patients. **We recommend maintaining the current work RVU of 7.96. We also recommend the survey median time and visits which include E/M work on the day of the procedure and 1 x 99238 for the discharge work provided the next day, if the patient can safely be released from the hospital.**

With respect to the E/M work on the day of the procedure, we believe the typical service is equivalent to 99231 because the typical patient is admitted to the surgical ward by the surgeon's orders and until the patient is discharged, the work being performed is inpatient. However, if semantics require use of different codes, then we might suggest using the following two codes as proxies: 99218 *Observation care* for work on the day of the procedure and 99217 *Observation care discharge* for work the following day. The use of these proxies will require a change to the SoR and the RUC database because these codes are not currently identified. However, we do not suggest adding these codes – which would only be proxies for work – to the RUC 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49587

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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. National frequency unknown, but typical patient is not Medicare aged.

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?
9,664 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. 2006 Medicare database

Specialty general surgery Frequency 8814 Percentage 91.20 %

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? No

If no, please select another crosswalk and provide a brief rationale. Use current code 49587

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

	Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings							Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings								Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1		60	0	L037D			4	0		0			-1	1		Yes	9
28120	50	50	1	0	3	2	0	67	-17	L037D	1	0	3.5	0	0	-17	0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0	51	-6	L037D	1	0	5	0	0	-6	0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0	60	30	L037D	1	0	4	0	0	0	0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0	120	-20	L037D	1	0	0	5	0	0	0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0	81	39	L037D	1	0	2.5	0	0	0	0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0	156	-6	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0	182	-2	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0	67.5	2.5	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0	90	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0	60	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
69100	12	8						10	2	L037D						1						No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
February 2009

Cryoablation of Prostate

In June 2008, CMS requested the RUC to review non-facility setting direct practice expense recommendations for CPT Code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement).* The American Urological Association's Quality Improvement and Patient Safety Committee maintained that 55873 may be performed in the office setting assuming that a Class C surgical facility designation for anesthesia has been achieved. The RUC reviewed the direct practice expense recommendation in the non-facility setting as presented by the specialty and realized the service was initially reviewed as a new code by the RUC in February 2001. RUC members believed that the intra-service physician time since the RUC' initial review had declined (from 200 minutes) as the service is now more often performed. The RUC agreed with the specialty that the service should be surveyed for physician work for presentation with revised direct practice expense input information at the RUC's January 29 – February 1, 2009 meeting.

1834

At the RUC's January 29 – February 1, 2009 meeting the specialty society provided a clear description of the service being provided. The survey respondents had chosen CPT code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (Work RVU = 13.31) as its key reference service. RUC members had expressed their concern regarding the high intra-service work per unit of time (IWPUT) and the change in intra-service time from the previous survey performed eight years prior. The specialty explained that the performance of the procedure has changed and the intensity had increased. The monitoring of multiple body data points for temperature change simultaneously, the placement of multiple probes, and the reduction of time of obtaining and maintaining a -40F ice ball formation, has increased the intensity and reduced the intra-service time. In addition, it was explained that the risk of patient injury during the entire procedure is quite high.

The RUC agreed that the work value for code 55873 is similar to the specialty's key reference service 55875. However, the RUC did not agree with the specialty's recommended value of 15.50. The RUC reviewed its previous recommendation from February 2001 which was established through a building block methodology with an intra-service work per unit of time (IWPUT) of 0.071. RUC members understood that from the recent survey the intra-service time is lower (100 rather than 200 minutes) and a higher intensity and complexity has been recognized than when the code was first surveyed. Due to a more complex and intense monitoring of the organs and ablated area, RUC members concurred that the intensity of 55873 is between the specialty survey's key reference service code 55873 (IWPUT = 0.0948) and its originally determined intensity of 0.071 established from CPT code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and*

obturator nodes (Work RVU = 30.52). The RUC agreed the IWPUT to be approximately 0.083 which is precisely between the IWPUT of 55845 and 55873. Using the specialty's surveyed physician time components and an IWPUT of 0.083 the RUC constructed a building block methodology that resulted in a work relative value of **13.45** for CPT code 55873.

The RUC agreed that an anchor code and a building block approach would also be useful at establishing the correct value. The RUC considered several similar services with a range of complexities including code 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (Work RVU = 9.08, IWPUT = 0.064). Code 50593 has 90 minutes of intra-service time, however the ultrasound guidance needed to place the needles is coded separately, and the insertion of a superpubic catheter is required for cryoablation of the prostate. Adding up these components was agreed be appropriate in establishing the physician work value for code 55873. The RUC agreed that although the physician work for code 55873 is similar to code 50593, it is more intense and concurred the intensity of 0.083 needed to be maintained.

The RUC then took 90 minutes of intra-service work time out of code 50593 at an IWPUT of 0.064 (0.064 X 90 = 5.76) and replaced with 90 minutes of work at an IWPUT of 0.083 (0.083 X 90 = 7.47) to arrive at a beginning value of 10.79. (7.47 – 5.76 = 1.71 RVUs + 9.08 = 10.79). The insertion of a superpubic catheter and the ultrasound guidance are then added to arrive at a value similar to 13.45 as shown below.

1835

This building block utilizes the work the following three codes:
50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (Work RVU = 9.08 +1.71 (intensity RVU difference) = 10.79.
51102 *Aspiration of bladder; with insertion of suprapubic catheter* (Work RVU = 2.70 X 50% (multiple procedure reduction) = 1.35)
76965 *Ultrasonic guidance for interstitial radioelement application* (Work RVU = 1.34)

10.79
+1.35
+1.34
13.48

The RUC's building block and IWPUT methodologies led them approximately to the same physician work value of 13.45 RVUs. The RUC also reviewed and compared the work of codes 49565 *Repair recurrent incisional or ventral hernia; reducible* (Work RVU = 12.29, 100 minutes intra-service time), 58550 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;* (Work RVU = 14.97, 100 minutes intra-service time), and 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (Work RVU = 14.95, 100 minutes intra-service time). After developing a building block methodology, reviewing similar procedures with 100 minutes of intra-service time and intensity ranges, **the RUC recommends a relative work value of 13.45 for CPT code 55873.** This value preserves the rank order between 55873 and its key reference code 55875.

Practice Expense: The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring	090	13.45

1836

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:55873 Tracking Number Specialty Society Recommended RVU: **15.50**

Global Period: 090 RUC Recommended RVU: **13.45**

CPT Descriptor: Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 year-old man with clinically localized prostate cancer, having considered all available treatment options, has elected to have cryosurgical ablation of the prostate. NOTE: Placement of a suprapubic tube (trocar technique) is included in the work of this procedure. All postoperative care for 90 days is included.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

Percent of survey respondents who stated they perform the procedure; In the hospital 92% , In the ASC 8%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 56% , Kept overnight (less than 24 hours) 38% , Admitted (more than 24 hours) 6%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 46%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 22%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 5%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropiate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropiately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is in the dorsal lithotomy position. A cystoscopy is performed. The skin of the perineum and suprapubic area is prepped and draped and the bladder palpated. The bladder is filled in a retrograde fashion using a syring or catheter. A trocar puncture is made into the bladder. A guidewire is introduced into the bladder through the sheath once the trocar itself is removed. A skin incision is made to facilitate catheter advancement over the guidewire. A suprapubic tube is placed. This accomplished, the guidewire is removed, the balloon inflated, return checked through the catheter port, and the catheter sutured to the skin. A guidewire is then placed into the bladder through the urethra and a urethral warming device is advanced into the bladder over the guidewire. The guidewire is then removed. The transrectal ultrasound probe is positioned in the rectum. Multiple needle passes are made into the prostate through the perineum. The stylet of each needle is removed and an angle tipp wire advanced through the needle into the prostate. The needle sheath is then removed. The process is repeat multiple times until all needles have been replaced with angle tipped wires. A small incision is made on the perineum where each guidewire enters the skin to facilitate passage of a series of sequential dilators. Using these dilators, a tract is made through the perineum and pelvic floor into the prostate. Finally, multiple cryosurgical probes are placed over the guidewires and into the prostate under ultrasonic guidance. The cryoprobes are cooled to the appropriate setting.

The initial freeze takes approximately 15 minutes followed by 15 minutes of thaw time. The second freeze time is approximately 15 minutes followed by 15 minutes of thaw time. The iceball's growth and regression is monitored with ultrasound. A second freeze is routinely done. A third freeze may be done in the area of the urethral diaphragm and prostatic apex by withdrawing the posterior probes. After all areas are treated, the cryoprobes are thawed and removed. The cryoprobe sheath sites in the perineum may be closed with sutures. A compression dressing applied.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. A detailed operative report is dictated. The surgeon talks with the patients family about the procedure, diagnosis and post operative care. The patient is either admitted to the hospital or dismissed home later that day after being assessed by the surgeon. Hospital by-laws require that a detailed dishcarge summary must be dictated. All postoperative care for 90 days is included.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2009				
Presenter(s):	James Giblin, MD; Richard Gilbert, MD; Mark Chelsky, MD				
Specialty(s):	Urology				
CPT Code:	55873				
Sample Size: 84	**Resp N:** 37	**Response:** 44.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	10.00	**20.00**	30.00	200.00
Survey RVW:	12.54	15.50	**21.18**	25.00	52.50
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	60.00	90.00	**100.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38,, 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	55873	**Recommended Physician Work RVU: 15.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**8.00**	**3.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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	Work RVU	Time Source	Most Recent Medicare Utilization
63047	090	15.22	**RUC Time**	74,815

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.67	**RUC Time**	18,817

CPT Descriptor 2 Mastectomy, simple, complete

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 32.4 %

TIME ESTIMATES (Median)	CPT Code: 55873	Key Reference CPT Code: 55875	Source of Time RUC Time
Median Pre-Service Time	56.00	50.00	
Median Intra-Service Time	100.00	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	
edian Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	69.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**274.00**	**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	4.75	4.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.92
Urgency of medical decision making	3.33	3.25

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	3.83
Physical effort required	3.58	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.92	3.50
Outcome depends on the skill and judgment of physician	4.42	3.75
Estimated risk of malpractice suit with poor outcome	3.83	3.42

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.25	4.08
Intra-Service intensity/complexity	4.25	3.67
Post-Service intensity/complexity	3.33	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.*

SERVICES REPORTED WITH MULTIPLE 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) 55873

low often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
if the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Information was provided by industry.

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? 4,863 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. RUC database

ecialty 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. Surgical

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
010 or 090 Day Global Periods
Non Facility/Facility Direct Inputs

CPT Long Descriptor: Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The recommendations were developed by a Panel consisting of five physicians who represent urological practices from across the United States in single specialty groups in suburban and urban settings. They represent the states of Washington, Illinois, Virginia, Wisconsin, and New York. The panel reviews current information, makes recommendations and these recommendations are submitted to the AMA.

Please describe the clinical activities of your staff:
Pre-Service Clinical Labor Activities:
Pre-service screening
Test and examination results
Informed consent
Assure proper authorization/referral/precertification
Organize all necessary personnel for procedure
Organize all necessary personnel and services for the intra-service period
Answer questions from patient and family (face to face and telephone)
Day of Procedure
Review charts
Greet patient and provide gowning
Obtain vital signs
Provide pre-service education and obtain consent
Prepare room, equipment, supplies
Prepare and position patient/monitor patient/set up IV

Intra-Service Clinical Labor Activities:

Staff 1 - Assist MD in performing procedure (100%)
Test cryo probe
Prepares patient
Assist physician with cystoscopy procedure and suprapubic tube placement
Assist physician with foley catheter placement
Hands cryo probe to physician for placement
Monitors patient during freeze and thaw process

Staff 2 – Assist MD in performing procedure (75%)
Bring machine into room and put in position for procedure
Test cryo probe
Set up ultrasound machine and assist physician with ultrasound
Assist in treatment planning

Assist physician with probe placement according to treatment plan
Monitor ultrasound for probe placement
Determine number of probes to be placed with physician
Operate thermal machine and set levels for freezing
Monitor freezing and thawing of iceball in prostate

Post-Service Clinical Labor Activities:
Monitor patient following service/check tubes, monitors, drains
Clean room/equipment by physician staff
Examination of perineum and suprapubic area
Cleaning wound and apply new dressing
Help patient dress
Patient education
Calling in prescription
Preparing and cleaning room
Sterilizing instruments

	A	B	C	D
1			55873	55873
2	**Meeting Date: February 2009** **Specialty: American Urological Association**	**CMS Code**	**Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**	**Cryosurgical ablation of the prostate (includ ultrasonic guidanc and monitoring)**
3	**LOCATION**		**Non Facility**	**Facility**
4	**GLOBAL PERIOD**		**90**	**90**
5	**TOTAL CLINICAL LABOR TIME**	**L037D/ L051B**	**394.0**	**168.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**35.0**	**60.0**
7	**STAFF 1 - INTRA CLINICAL LABOR TIME**	**L037D**	**176.0**	**0.0**
8	**STAFF 2 - INTRA CLINICAL LABOR TIME**	**L051B**	**75.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		**108.0**	**108.0**
10	**PRE-SERVICE**			
11	**Start: Following visit when decision for surgery or procedure made**			
12	Complete pre-service diagnostic & referral forms	**L037D**	**5**	**5**
13	Coordinate pre-surgery services	**L037D**	**10**	**20**
14	Schedule space and equipment in facility	**L037D**	**0**	**8**
15	Provide pre-service education/obtain consent	**L037D**	**10**	**20**
16	Follow-up phone calls & prescriptions	**L037D**	**10**	**7**
17	**End: When patient enters office/facility for surgery/procedure**			
18	**SERVICE PERIOD**			
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**			
20	Review charts	**L037D**	**0**	
21	Greet patient and provide gowning	**L037D**	**3**	
22	Obtain vital signs	**L037D**	**3**	
23	Provide pre-service education/obtain consent	**L037D**	**0**	
24	Prepare room, equipment, supplies	**L037D**	**2**	
25	Setup scope (non facility setting only)	**L037D**	**5**	
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	**2**	
27	Sedate/apply anesthesia	**L037D**	**0**	
28	**Intra-service**	**L037D**		
29	**Staff 1 - Assist MD in performing procedure (100%)**	**L037D**	**100**	
30	**Staff 2 - Assist MD in performing procedure (75%)**	**L051B**	**75**	
31	**Post-Service**			
32	Monitor pt. following service/check tubes, monitors, drains	**L037D**	**1**	
33	Clean room/equipment by physician staff	**L037D**	**3**	
34	Clean Scope	**L037D**	**30**	
35	Clean Surgical Instrument Package	**L037D**	**10**	
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	**3**	
37	Discharge day management	**L037D**	**6**	
38	**End: Patient leaves office**			
39	**POST-SERVICE Period**			
40	**Start: Patient leaves office/facility**			
41	Conduct phone calls/call in prescriptions			
42	*Office visits:*			
43	*List Number and Level of Office Visits*			
44	99211 16 minutes			
45	99212 27 minutes			
46	99213 36 minutes		**3**	**3**
47	99214 53 minutes			
48	99215 63 minutes			
49	Other			
50	*Total Office Visit Time*		**108**	**108**
51	Other Activity (please specify)			

	A	B	C	D
1			55873	55873
2	**Meeting Date: February 2009** **Specialty: American Urological Association**	**CMS Code**	**Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**	**Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**
3	**LOCATION**		**Non Facility**	**Facility**
53	**MEDICAL SUPPLIES**			
54	pack, minimum multi-specialty visit	**SA048**	**4**	
55	pack, cleaning and disinfecting	**SA042**	**1**	
56	pack, urology cystoscopy visit	**SA058**	**1**	
57	gloves, sterile	**SB024**	**8**	
58	drape, sterile barrier 16in x 29in	**SB007**	**1**	
59	drape-towel, sterile 18in x 26in	**SB019**	**2**	
60	drape, sterile for mayo stand	**SB012**	**2**	
61	povidone surgical scrub (Betadine)	**SJ042**	**50**	
62	cover-condom, transducer or ultrasound probe	**SB005**	**1**	
63	kit, probe, cryoablation, prostate (See invoice - Item #3 on Galil/Page 2 Endocare)	**NEW**	**1**	
64	gas, argon @ $.025 per cu ft (See invoice for Air Liquide)	**NEW**	**523**	
65	gas, helium @ $0.41 per cu ft	**SD079**	**473**	
66	drape-sleeve, sterile (4in x 8ft)	**SB017**	**2**	
67	drape-sleeve, sterile, for handpiece	**SB018**	**1**	
68	lidocaine 4% soln, topical (Xylocaine)	**SH050**	**2**	
69	applicator, cotton-tipped, sterile, 6in	**SG081**	**2**	
70	swab-pad, alcohol	**SJ053**	**4**	
71	lidocaine 1% w-epi inj (Xylocaine w-epi)	**SH046**	**20**	
72	needle, 18-27g	**SC029**	**4**	
73	cup, sterile, 8 oz	**SL157**	**1**	
74	basin, sterile, 500 cc		**1**	
75	sodium chloride 0.9% inj (250-1000ml uou)	**SH067**	**1**	
76	syringe 20ml	**SC053**	**1**	
77	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**2**	
78	sanitizing cloth-wipe (patient)	**SM021**	**2**	
79	drainage bag	**SJ031**	**1**	
80	foley catheter	**SD024**	**1**	
81	leg bag	**SD074**	**1**	
82	Guidewire	**SD088**	**1**	
83	Tray, shave prep	**SA067**	**1**	
84	kit, catheter, suprapubic	**SA006**	**1**	
85	**scalpel, safety, surgical, with blade (#10-20)**	**SF047**	**1**	
86	**EQUIPMENT**			
87	table, power	**EF031**	**1**	
88	light, exam	**EQ168**	**1**	
89	mayo stand	**EF015**	**1**	
90	ultrasound unit, Shimadzu	**EQ250**	**1**	
91	Cryoablation unit, Presice Cryotherapy System with urethral warmer and ultrasound support (See invoice - Item 1/2/5 Galil & Page 1 Endocare)	**NEW**	**1**	
92	cysto, flexible	ES018	**1**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Hysteroscopy

At the request from the Centers for Medicare and Medicaid Services, the RUC reviewed a list of direct practice expense input changes specific to the following CPT codes:
58555 *Hysteroscopy, diagnostic (separate procedure)*
58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C*
58562 *Hysteroscopy, surgical; with removal of impacted foreign body*
58563 *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)*

The specialty society noticed that some practice expense items for the typical service, needed to be included. The RUC reviewed these practice expense additions carefully and agreed with the specialty's recommendations. They agreed that a pack for cleaning surgical instruments, already included in the practice expense items for these services, is necessary in addition to the pack for cleaning and disinfecting the endoscope because the hysteroscopy services need a speculum, a tenaculum, and other sterile equipment to access the uterus, in addition to the endoscopy instruments. The cystoscopy pack is required for installation of the distention fluid and is in addition to the exam pack that is now recommended. **The RUC recommends the following additions and deletions to the direct practice expense inputs:**

1. **58555**- *Hysteroscopy, diagnostic (separate procedure)*
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. SB001-Cap, Surgical
    d. SB027-Gown, Staff, impervious
    e. SB034-Mask Surgical, with face shield
    f. SB039-Shoe Cover, Surgical
    g. SJ036- Monsel's Soln
    h. SC053- Syringe, 20 ml
    i. **Remove Items:** (SB024-Gloves- sterile, SJ041-Povidone Soln Betadine, SC062 Toomey syringe)

2. **58558**- *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C*
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. SB001-Cap, Surgical
    d. SB027-Gown, Staff, impervious
    e. SB034-Mask Surgical, with face shield
    f. SB039-Shoe Cover, Surgical
    g. SJ036- Monsel's Soln
    h. SC053- Syringe, 20 ml
    i. **Remove Items:** (SB024 Gloves-sterile, SJ041-Providone Soln Betadine, SC062 Toomey syringe)

3. **58562**- *Hysteroscopy, surgical; with removal of impacted foreign bo*dy
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. SB001-Cap, Surgical
    d. SB027-Gown, Staff, impervious
    e. SB034-Mask Surgical, with face shield
    f. SB039-Shoe Cover, Surgical
    g. SJ036- Monsel's Soln
    h. SC053- Syringe, 20 ml
    i. **Remove Items:** (SB024 Gloves-sterile, SJ041-Providone Soln Betadine, SC062 Toomey syringe)

4. **58563**- *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)*
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. **Remove Items:** (SM018 Glutaraldehyde 3.4% Cidex, Maxicide, Wavicide, SH048-Lidocaine 2% jelly, topical (Xylocaine), SH069- Sodium chloride 0.9% irrigation (500-1000ml), SD129 Tubing, irrigation(Cysto), SD118 (-1) vaginal specula)

1857

CPT Code (•New)	CPT Descriptor	Global Period	RUC Recommendation
58555	Hysteroscopy, diagnostic (separate procedure)	000	Practice Expense Only
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	000	Practice Expense Only
58562	Hysteroscopy, surgical; with removal of impacted foreign body	000	Practice Expense Only
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	000	Practice Expense Only

1858

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review

February 2009

Obstetric Procedures

The Five Year Review Identification Workgroup identified the following codes as potentially misvalued through the High IWPUT Screen and the RUC recommended that they be surveyed: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622. The RUC referred development of an MMM survey instrument to the Research Subcommittee with input from the specialty society at its October 2008 meeting. The Research Subcommittee has worked with the specialty since that time to develop a survey method to review these codes. The survey and process was finalized at the April 2009 RUC meeting. Data will be collected and presented at the October 2009 RUC meeting.

1860

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	MMM	Defer to October 2009
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	MMM	Defer to October 2009
59410	including postpartum care	MMM	Defer to October 2009
59412	External cephalic version, with or without tocolysis	MMM	Defer to October 2009
59414	Delivery of placenta (separate procedure)	MMM	Defer to October 2009
59425	Antepartum care only; 4-6 visits	MMM	Defer to October 2009
59426	7 or more visits	MMM	Defer to October 2009

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
59430	Postpartum care only (separate procedure)	MMM	Defer to October 2009
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	MMM	Defer to October 2009
59515	Cesarean delivery only; including postpartum care	MMM	Defer to October 2009
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	MMM	Defer to October 2009
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	MMM	Defer to October 2009
59614	including postpartum care	MMM	Defer to October 2009
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	MMM	Defer to October 2009
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	MMM	Defer to October 2009
59622	including postpartum care	MMM	Defer to October 2009

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review

February 2009

Cranial Neurostimulators

CPT codes 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*, and 64573 *Incision for implantation of neurostimulator electrodes; cranial nerve* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008.

The specialty societies presented information to the RUC that as a result of recent developments in the use of vagal nerve stimulators, there are some concerns about the use of 61885 and 64573 with respect to these procedures. The specialty societies are bringing forth a CPT coding proposal to revise 61885 and 64573 to better describe revision of a vagal nerve stimulator lead and the placement of the pulse generator and replacement or revision of the vagus nerve electrode. The specialties requested that the RUC review of CPT codes 61885 and 64573 be postponed until a revision of the descriptors for these codes has been reviewed by the CPT Editorial Panel.

The RUC agreed with the specialty societies and recommended referral of 61885 and 64573 to the CPT Editorial Panel.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	090	Referral to the CPT

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
			Editorial Panel
64573	Incision for implantation of neurostimulator electrodes; cranial nerve	090	Referral to the CPT Editorial Panel

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
CMS Request

April 2009

Fluoroscopy – Practice Expense Recommendation

The Physician Consortium for Performance Improvement (PCPI) is developing a measure related to the use of fluoroscopy. The PCPI reviewed all services where fluoroscopy was included in the practice expense direct inputs to determine the denominator codes. The American College of Radiology suggested that seven services may not typically be performed with fluoroscopy. CMS requested that the RUC consider deleting these expenses from the inputs for these seven services. Other specialties were provided with the opportunity to review the issue and determine what room is typically used in providing the service. The RUC reviewed each service and concurred with the specialty societies that codes 64520, 64622, and 64626 provide fluoroscopy and require a radiographic-fluoroscopic room.

1864

The RUC determined that code 64510 is performed in a examination room and services 76100 - 76102 are performed in an X-ray room. **The RUC recommends that the equipment item EL014 Room, radiographic-fluoroscopic is appropriate for 64520, 64622, and 64626 and will notify PCPI staff. The RUC also recommends the replacement of equipment item EL014 Room, radiographic-fluoroscopic to an exam table (EF023) for 64510 and a Basic Radiology Room (EL012)for CPT codes 76100, 76101, and 76102.**

CPT Code	CPT Descriptor	Global Period	Practice Expense Only Recommendation
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	000	PE Recommendation only to change fluoroscopic room (EL014) to exam table (EF023)
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	000	(No Change – will inform PCPI staff that fluoroscopy is typically used)

CPT Code	CPT Descriptor	Global Period	Practice Expense Only Recommendation
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level (For bilateral procedure, report 64622 with modifier 50)	010	(No Change – will inform PCPI staff that fluoroscopy is typically used)
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level (For bilateral procedure, report 64626 with modifier 50)	010	(No Change – will inform PCPI staff that fluoroscopy is typically used)
76100	Radiologic examination, single plane body section (eg, tomography), other than with urography	XXX	(No Change – PE Recommendation only to change fluoroscopic room (EL014) to a Basic Radiology Room (EL012))
76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	XXX	(No Change – PE Recommendation only to change fluoroscopic room (EL014) to a Basic Radiology Room (EL012))
76102	bilateral (For nephrotomography, use 74415)	XXX	(No Change – PE Recommendation only to change fluoroscopic room (EL014) to a Basic Radiology Room (EL012))

1865

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five-Year Review

April 2009

Biopsy of Ear

The RUC identified 69100, *Biopsy external ear*, as potentially misvalued based on the recommendation of the Five Year Review Identification Workgroup. The code was referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that 69100 be surveyed for April 2009.

The specialty society indicated that it would pursue deletion of 69100 from CPT, as the work commonly reported under this code can be reported more efficiently by using 11100, *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU = 0.81). The specialty societies were unable to complete their coding change application in time for CPT 2010, and 69100 will appear in the CPT book until CPT 2011. Subsequently, the specialty surveyed the procedure to develop an appropriate work RVU until the service is deleted from CPT. In its comments regarding deletion of 69100 and migration to use of 11100, the specialty noted that the practice expense RVU associated with 11100 is slightly lower that that of 69100. Further, the specialty noted that 69100 may be reported multiple times within the same visit on the same patient, whereas 11100 should be reported only once.

The specialty presented the results from a survey of 38 dermatologists. The surveyees indicated a median work RVU of 0.92, which is slightly higher than the current work RVU of 0.81, which was developed during the Harvard survey process and validated by the RUC during the first Five-Year Review without a survey. The specialty society expert panel reviewed the survey physician time and made minor changes to the intra-service time, reducing it by one minute to twelve minutes. The survey respondents indicated a median pre-service time of 7 minutes, which the specialty society expert panel agreed with. Survey respondents identified key reference service 11100, which is similar and often identical to the surveyed code. Because of the specialized location of the biopsy, the specialty society expert panel agreed with the survey respondents that an additional two minutes of pre-service time is required. However, the expert panel did not agree that there should be any difference in the work RVU. The RUC agreed with the specialty society presenters that the work of 69100 is identical to 11100 and should be valued the same. **Therefore, the RUC approved the amended physician time of 7 minutes pre-service evaluation, 12 minutes intra-service, and 5 minutes immediate post-service time and a physician work RVU of 0.81 for CPT code 69100, until it is deleted from CPT.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
69100		Biopsy external ear	000	0.81 (No Change)

American Academy of Dermatology

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Wednesday, May 20, 2009

TAB 29

William Rich, M.D. Chair
AMA/Specialty Society RVS Update Committee
515 North State Street
Chicago, IL 60610

Barbara Levy, Chair
Five-Year Review Identification Workgroup

RE: Code Assignment for 69100

Dear Dr. Rich, and Dr. Levy
The American Academy of Dermatology (AAD) respectfully submits the following comments and data in response to the Five Year Review Identification Work Group's Assignment of CPT 69100 for the April 09 AMA RUC Meeting. As required, AAD has surveyed this code and submits the attached Summary of Recommendation (SoR) form summarizing that data.

This code was identified because it is a procedure with increased utilization that has never been surveyed by the RUC. The RUC 5YR ID Workgroup accepted the AAD work plan to survey the code in preparation for the April 09 RUC meeting. AAD requested and received CMS data on the frequency of biopsy and site specific biopsies performed at the same time as an E&M service. The Workgroup asked that we provide data regarding evaluation and management on the same date. This data is included in the SoR.

The American Academy of Dermatology conducted a random survey among its members and the results reviewed and analyzed by our RB/RVS Work Group. Although some of the survey respondents indicated a measurable difference in time and difficulty for CPT 69100, the majority of respondents consistently ranked it as essentially equal to the reference code, CPT 11100 skin biopsy. The proposed recommended values are the 25th percentile for intra time of 12 min and PW/RVU value of 0.87 RVUs.

Survey findings suggest that CPT 69100 should be considered redundant to 11100, a position maintained by our work group and an action plan which should have been pursued. Dermatology currently has +90% utilization of this code. Deletion of this code would result in annual savings to Medicare in the difference in Medicare Fee Schedule payment for 69100 vs 11100. This current difference is probably accounted for in minor PE differences between the 2 codes. If accepted, deletion of 69100 would result in current annual Medicare utilization for this code shifting to CPT 11100.

We have requested comment from otolaryngology regarding revising or deleting this code, but to date, have not received their definitive feedback, but in emails have been told it was most likely acceptable to them to delete this code.

If you have questions regarding this submission, please contact Norma L. Border at 847 240 1814 or nborder@aad.org.

Sincerely,

Brett Coldiron MD

Brett Coldiron, M.D., FAAD, FACP
AAD Advisor to the AMA/Specialty Society RVS Update Committee

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69100 Tracking Number Specialty Society Recommended RVU: **0.81**

Global Period: 000 RUC Recommended RVU: **0.81**

CPT Descriptor: Biopsy external ear

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old woman with extensive actinic damage presents with a 6mm scaly erythematous nodule on the inner helix of the R ear. The differential involves an invasive squamous cell carcinoma, a basal cell carcinoma and chondrodermatitis nodularis helicis.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Prior to biopsy of lesion, obtain pertinent history from patient to include: previous skin cancer, prior treatment history, sun protection history, etc. Discussion with patient will include: indication for biopsy procedure, risks, and benefits; description of biopsy procedure method, and expected result and/or scarring. In addition, patient agreement/informed consent is obtained and staff is advised for preparation of patient and necessary anesthetic, supplies, and instrument tray preparation.

Description of Intra-Service Work: inspection and palpation of the lesion to assess depth and to select most representative site to obtain specimen. Cleanse biopsy site with suitable antiseptic; inject appropriate local anesthetic; apply sterile drapes; obtain skin specimen with scalpel, skin punch, or suitable instrument depending on depth and amount of tissue needed. Collect specimen in labeled formalin container. Undermine wound edges as needed to facilitate repair. Suture to approximate wound edges, or achieve hemostasis with pressure, chemical, or electrocautery, or application of topical hemostatic agents. Apply antibiotic ointment and sterile dressing.

Description of Post-Service Work: instruction of patient and/or family on postoperative wound care, dressing chang and follow-up. Patient advised how to recognize significant complications, eg, bleeding, or allergic reaction to antibio ointment or adhesive dressings. Patient advised when results will be available and how they will be communicated; completion of medical record; and communication of results to referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Scott Collins, MD,				
Specialty(s):	Dermatology				
CPT Code:	69100				
Sample Size:	125	**Resp N:**	38	**Response:** 30.4 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	15.00	**23.50**	42.25	125.00
Survey RVW:	0.81	0.87	**0.92**	0.95	1.10
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	12.00	**13.00**	17.00	21.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	69100	**Recommended Physician Work RVU: 0.81**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**-0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**12.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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
11100	000	0.81	**RUC Time**

CPT Descriptor Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11420	010	1.00	**RUC Time**	32,037

CPT Descriptor 1 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11440	010	1.02	**RUC Time**	59,314

CPT Descriptor 2 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 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: 33 **% of respondents:** 86.8 %

TIME ESTIMATES (Median)	CPT Code: 69100	Key Reference CPT Code: 11100	Source of Time RUC Time
Median Pre-Service Time	7.00	5.00	
Median Intra-Service Time	12.00	12.00	
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	**24.00**	**22.00**	

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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.97	2.97
Urgency of medical decision making	2.80	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	3.11
Physical effort required	2.97	2.97

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	3.69	3.00
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	2.12	2.12
Intra-Service intensity/complexity	3.86	2.97
Post-Service intensity/complexity	3.02	3.02

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an RVPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was identified because it is a procedure with increased utilization that has never been surveyed by the RUC. The RUC 5YR ID Workgroup accepted the AAD work plan to survey the code in preparation for the April 09 RUC meeting. AAD requested and received CMS data on the frequency of biopsy and site specific biopsies performed at the

same time as an E&M service. The Workgroup asked that we provide data regarding evaluation and management on the same date. This data is included in the SoR.

The American Academy of Dermatology conducted a random survey among its members and the results reviewed and analyzed by our RB/RVS Work Group. Although some of the survey respondents indicated a measurable difference in tir and difficulty for CPT 69100, the majority of respondents consistently ranked it as essentially equal to the reference code, CPT 11100 skin biopsy. The proposed recommended values are the 25th percentile for intra time of 12 min and PW/RVU value of 0.87 RVUs.

Survey findings suggest that CPT 69100 should be considered redundant to 11100, a position maintained by our work group and an action plan which should have been pursued. Dermatology currently has +90% utilization of this code. Deletion of this code would result in annual savings to Medicare in the difference in Medicare Fee Schedule payment for 69100 vs 11100. This current difference is probably accounted for in minor PE differences between the 2 codes. If accepted, deletion of 69100 would result in current annual Medicare utilization for this code shifting to CPT 11100.

We have requested comment from otolaryngology regarding revising or deleting this code, but to date, have not received their definitive feedback, but in emails have been told it was most likely acceptable to them to delete this 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) Reported with E&M visit 43%

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) 69100

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 Dermatolgy How often? Commonly

Specialty Otolaryngology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 125000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. Utilization suggests Medicare population has 66% incidence.

Specialty Dermatology Frequency 113200 Percentage 90.56 %

Specialty Otolaryngology Frequency 3750 Percentage 3.00 %

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? 82,587 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on Medicare utilization data.

Specialty Dermatology Frequency 74791 Percentage 90.56 %

Specialty Otolaryngology Frequency 2478 Percentage 3.00 %

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.

ıdicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests where Physician Work and Time were Reviewed
February and April 2009 RUC Meetings

	Practice Expense Physician Time Components Recommended February and April 2009 RUC Meetings							Practice Expense Physician Time Components prior to the February and April 2009 RUC Meetings									Change in Post Op Visit Info						
CPT Code	Intra-Service	Clinical Labor Assist	99238	99211	99212	99213	99214	Current Intra Time	Change in Intra time	Staff Type	99238	99211	99212	99213	99214	Change in Clinical Labor from change in Intra time	99238	99211	99212	99213	99214	Change in Post Op Visits	Change in Clinical Labor Time from Change in Post Op Visits
26480	60	0	0.5		3	1		60	0	L037D			4	0		0			-1	1		Yes	9
28120	50	50	1	0	3	2	0	67	-17	L037D	1	0	3.5	0	0	-17	0	0	-0.5	2	0	Yes	58.5
28122	45	45	1	0	2	2	0	51	-6	L037D	1	0	5	0	0	-6	0	0	-3	2	0	Yes	-9
28725	90	0	1	0	2	3	0	60	30	L037D	1	0	4	0	0	0	0	0	-2	3	0	Yes	54
28730	100	0	1	0	2	3	0	120	-20	L037D	1	0	0	5	0	0	0	0	2	-2	0	Yes	-18
36825	120	0	1	0	1	2	0	81	39	L037D	1	0	2.5	0	0	0	0	0	-1.5	2	0	Yes	31.5
42415	150	0	1	0	1	2	0	156	-6	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
42420	180	0	1	0	1	2	0	182	-2	L037D	1	0	0	3.5	0	0	0	0	1	-1.5	0	Yes	-27
49507	70	0	1	0	1	1	0	67.5	2.5	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49521	90	0	1	0	1	1	0	90	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
49587	60	0	1	0	1	1	0	60	0	L037D	1	0	1	1	0	0	0	0	0	0	0	No	0
69100	12	8						10	2	L037D						1						No	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

Originated from Five-Year Review

April 2009

Soft Tissue Ultrasound

The RUC identified 76536, *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation*, as potentially misvalued based on the recommendation of the Five Year Review Identification Workgroup. The code was referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that 76536 be surveyed.

The specialty society presented evidence that the work for 76536 has changed since it was first valued. The specialty noted that the typical patient has changed due to the increasing incidence and prevalence of thyroid cancer. The specialty commented that the increased incidence of thyroid cancer results in a more complex patient. However, the RUC did not agree that a rise in the recognition of certain types of cancer necessarily increases the intensity or complexity of the existing mechanisms for diagnosis of the condition. The specialty next presented evidence that the improvement in technology, including color flow and power Doppler evaluation as well as increased transducer resolution increases the complexity of the examination and the expectations of the patient. The RUC commented that the improvement in technology may increase the information available to review, but that it concurrently improves the test's accuracy and readability, affording the practitioner a more reliable and revealing test result. Lastly, the specialty noted that the code had never been reviewed by the RUC and that the original data used to value to the service may not have included the current practitioners of the service. The RUC noted that lack of RUC review is not compelling evidence to consider an increase in the RVU under the RUC rules defining the review of services identified in the Five-Year Review Process and that there is no evidence that the CMS valuation of 76536 was either inclusive or not inclusive of radiologists and endocrinologists that provide this service. Therefore, the RUC did not agree that the compelling evidence standards, required to recommend a work RVU higher than the current value, for 76536 had been met.

The specialty society presenters provided evidence that the value of 76536 should not be reduced beyond its current work RVU of 0.56. The presenters provided the survey results of 63 radiologists and endocrinologists. The median work RVU identified by the surveyees was 1.00 and the 25th percentile work RVU was 0.74. The presenters noted that the existing total physician time within the RUC database is 18 minutes, which is not allocated between pre-service, intra-service, or post-service time. The survey respondents indicated that the existing physician time is somewhat under-representative and indicated times of 5 minutes pre-service, 15 minutes

intra-service and 5 minutes post-service time. However, the RUC queried and received the independent survey data of radiology vs. endocrinology. Radiologists indicated a lower intra-service time of 10 minutes, compared to 20 minutes for endocrinology.

Radiologist surveyees indicated a key reference service of 76776, *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU = 0.76, pre-service = 5 minutes, intra-service = 15 minutes, post-service = 5 minutes). The specialty society expert panel indicated that the appropriate physician time for 76536 should be less than 76776 as the reference service is valued slightly higher. Therefore, the specialty recommended physician times of 4 minutes pre-service, 10 minutes intra-service, and 4 minutes post-service. The RUC agreed that the work of 76776 is slightly greater than that of 76536, which justifies the difference in physician time. Further, the RUC agreed that given the survey results, the work RVU of 76536 should not be lower than its current value of 0.56 and that the current value appropriately ranks the service within its family. In further support of this recommendation, the RUC reviewed 99212, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family,*(work RVU = 0.45, pre-service = 2, intra-service = 10, post-service = 4). The RUC agreed that the two services are very similar and that the current work RVU for 76536 of 0.56 appropriately accounts for the additional pre-service time and slightly greater intensity. **Therefore, the RUC recommends that the current work RVU for 76536 be maintained at 0.56 and that the physician time be changes to 4 minutes pre-service evaluation, 10 minutes intra-service, and 4 minutes immediate post-service.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
76536		Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	XXX	0.56 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76536 Tracking Number Specialty Society Recommended RVU: **0.74**

Global Period: XXX RUC Recommended RVU: **0.56**

CPT Descriptor: Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 50 year old asymptomatic female originally found to have multiple thyroid nodules on routine physical examination by gynecologist one year ago. Initial assessment, including thyroid ultrasound, revealed no evidence of malignancy at that time. Patient now returns for annual follow-up of this condition and thyroid ultrasound is performed to re-evaluate the nodules.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an I&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 1%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
- Review pertinent clinical information, including history of thyroid or parathyroid disease and any previous thyroid biopsies
- Review any prior applicable imaging studies

Description of Intra-Service Work:

- Supervise technologist to ensure that the thyroid gland itself and any thyroid nodules have been measured in the same manner as the previous exam to facilitate accurate comparison review measurements of thyroid lobes and isthmus and assess for interval change in size between exams
- Evaluate overall echo texture of the thyroid
  Assess vascularity of the thyroid gland and thyroid nodules with color doppler imaging
  Review measurements of specific nodules and compare measurements to the previous exam
- Assess internal architecture of measured thyroid nodules for signs suggestive of tumor such as micro calcifications
- Evaluate and characterize surrounding anatomic structures to assess for possible adjacent lymphadenopathy or parathyroid tissue
- Generate report for the medical record

Description of Post-Service Work:

- Discuss significant findings such as change in nodule size or characteristics with the referring service
- Review and sign final report

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Bill Donovan, MD, Allan Glass, MD, and John Seibel, MD				
Specialty(s):	ACR, ASNR, AACE, TES				
CPT Code:	76536				
Sample Size:	789	**Resp N:**	63	**Response:** 7.9 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	60.00	**150.00**	393.00	5000.00
Survey RVW:	0.50	0.74	**1.00**	1.40	4.46
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	76536	**Recommended Physician Work RVU: 0.74**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**4.00**	**7.00**	**-3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**4.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11100	000	0.81	**RUC Time**	2,329,511

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	197,342

CPT Descriptor 2 Injection(s); single tendon origin/insertion

Other Reference CPT Code	Global	Work RVU	Time Source
76776	XXX	0.76	**RUC Time**

CPT Descriptor Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 23.8 %

TIME ESTIMATES (Median)	CPT Code: 76536	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	10.00	25.00	
Median Immediate Post-service Time	4.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**18.00**	**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	4.07	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	3.53	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	4.53	3.14
Physical effort required	3.47	2.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	3.00
Outcome depends on the skill and judgment of physician	4.73	4.00
Estimated risk of malpractice suit with poor outcome	4.20	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.53	2.36
Intra-Service intensity/complexity	4.00	3.71
Post-Service intensity/complexity	2.73	2.57

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dditional 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.*

ACR, ASNR, AACE, and TES convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The reference code selected most commonly was code 99214 (E/M service) with work value of 1.42. From the survey data the median recommended work value for code 76536 is 1.00, with times as follows: 5 min pre, 15 min intra, and 5 min post. The survey respondents indicated that code 76536 entails greater intensity and complexity than the 99214 reference code.

The societies are recommending the 25th percentile work value of 0.74 as well as the 25th percentile for physician time of 4 min pre, 10 min intra, and 4 min post. The panel believes that the 25th percentile values are more in line with another reference service code 76776 (Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation), which was the second most commonly selected reference code. Code 76776 was recently RUC valued and has a work value of 0.76 with 5 min pre, 10 min intra, and 5 min post, which is similar in RVU and time to our respondents' 25th percentile times. As such our panel elected to recommend the 25th percentile times for 76536. If the median times were maintained, the closest reference in the ultrasound family would be the recently RUC valued obstetrical ultrasound code 76801 with 0.99 RVU with 5 min pre, 15 min intra and 7 min post. The panel is not recommending 76536 be valued at that level because it would create a substantial number of rank order anomalies with other RUC valued ultrasound codes.

Since this code is part of the Five Year Review process, we recognize that compelling evidence standards must be met to change the value from the existing value. This meets a number of the requisites including the following:

Compelling Evidence for Change in Value:
1) Since the original valuation, the patient population has changed due to the increasing incidence and prevalence of thyroid cancer. This increases the complexity of the typical patient. Careful full neck lymph node assessment is essential for all thyroid cancer patients.

2) The technology available including color flow and power Doppler evaluation and increased transducer resolution increases the complexity of the examination and the expectation of the information it can provide.

3) This code has never been RUC surveyed. Applying the current survey data to the existing value would create rank order anomalies as compared to other RUC surveyed ultrasound codes.

4) The current survey includes input from a number of specialties performing the procedure, some of which did not have input into the original valuation.

SERVICES REPORTED WITH MULTIPLE 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) 76536

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology How often? Commonly

Specialty Endocrinology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1347000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 76536 in a one year period is estimated to be 915,960.

Specialty Radiology Frequency 915960 Percentage 68.00 %

Specialty Endocrinology Frequency 175110 Percentage 13.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 449,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2007 Medicare data estimates that CPT code 76536 was billed approximately 306,000 times.

Specialty Radiology Frequency 306000 Percentage 68.15 %

Specialty Endocrinology Frequency 56000 Percentage 12.47 %

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? No

If no, please select another crosswalk and provide a brief rationale. 76776. Physician work involved for code 76536 is more in line with code 76776.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Tab 29 - Soft Tissue Ultrasound																		
				Work RVU			Pre-time			Intra-time			Post-time			Service Perform Rate		
Specialty	# of surveys received	Ref selected	# selected ref code	25	median	75	25	median	75	25	median	75	25	median	75	25	median	75
Endo	31	99214	15	1.25	1.42	1.50	5	10	15	15	20	28	5	10	15	60	155	345
Rad	32	76776	7	0.65	0.75	0.83	3	5	5	8	10	15	2	4	5	80	150	500

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
CMS Request

April 2009

Radiation Treatment Delivery, Stereotactic Radiosurgery – Practice Expense Recommendation Only

In the 2009 *Final Rule*, CMS received comments including one from a single free-standing non-facility provider stating that the there was a drastic difference in payment between the proposed OPPS payment $7,608 and the PFS payment $1,260. Further, the commenters stated that existing practice expense inputs are incorrect because they excluded extra clinical labor time due to Nuclear Regulatory Commission (NRC) requirements for both the physicist and the registered nurse. Because of these comments, CMS requested that practice expense inputs associated with this service be reviewed.

The RUC reviewed the direct practice expense inputs as presented by the specialty society in response to the CMS 2009 *Final Rule.* The specialty had requested an additional 99 minutes of clinical labor time to account for moderate sedation in the intra-service time. The specific recommended changes to the intra-service time were:

1892

1. The specialty also recommended the elimination of the Registered Technician time and reassigning the remaining activities to Medical Physicist. (RUC agreed)
2. Changing several clinical labor activities from RN/LPN/MA to RN (RUC did not agree)
3. The addition of 10 minutes to the post monitoring time. (RUC agreed)
4. The addition of 45 minutes of RN assist physician time during the procedure for conscious sedation (RUC agreed)
5. Additional 44 minutes of time for miscellaneous activities (RUC did not agree)

In addition, the specialty requested minor changes to supplies and equipment. The RUC agreed with the specialty that additional time, supplies, and equipment were necessary to provide the service, however the RUC agreed to only 54 minutes of additional clinical labor time to assist in intra service and post service monitoring for moderate sedation. **The RUC recommends an additional 54 minutes of clinical labor time and other recommended medical supplies and equipment direct practice expense inputs as recommended by the specialty society for CPT code 77371. The RUC also recommends this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
⊙77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	XXX	0.00 (No Change – Practice Expense Recommendation Only)

1893

	A	B	C	D	E
1				CPT Code 77371	
2	Meeting Date: April 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Radiation treatment delivery, stereotactic radiosurgery (SRS); multi source Cobalt 60 based	
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME			288.0	15.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN.MA	9.0	12.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN.MA	14.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	77.0	
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L152A	MedPhys	185.0	0.0
10	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN MA	3.0	3.0
11	PRE-SERVICE				
12	**Start: Following visit when decision for surgery or procedure made**				
13	Complete pre-service diagnostic & referral forms	L037D	RN/LPN MA	3	3
14	Coordinate pre-surgery services	L037D	RN/LPN MA	3	3
15	Schedule space and equipment in facility	L037D	RN/LPN.MA		3
16	Provide pre-service education/obtain consent	L037D	RN/LPN.MA	3	3
17	Follow-up phone calls & prescriptions				
18	Other Clinical Activity (please specify)				
19	**End: When patient enters office/facility for surgery/procedure**				
20	SERVICE PERIOD				
21	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
22	Review charts	L037D	RN/LPN.MA	3	
23	Greet patient and provide gowning	L037D	RN/LPN.MA	3	
24	Obtain vital signs	L037D	RN/LPN.MA	3	
25	Provide pre-service education/obtain consent				
26	Prepare room, equipment, supplies	L037D	RN/LPN.MA	2	
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV				
29	Sedate/apply anesthesia	L051A	RN	2	
30	**Intra-service**				
31	Assist physician in performing procedure				
32	Patient Positioning System QA	L152A	MedPhys	*20*	
33	Enter treatment plan	L152A	MedPhys	*4*	
34	Review and check plan coordinates	L152A	MedPhys	*4*	
35	Assist in patient positioning	L152A	MedPhys	*8*	
36	Sets up plugs for collimator helmut	L152A	MedPhys	*5*	
37	Verify source strength and transmit plan to technology unit	L152A	MedPhys	*5*	
38	Verification of physical deliverability & rule out collision	L152A	MedPhys	*8*	
39	Treatment	L152A	MedPhys	*90*	
40	Change angle and collimators	L152A	MedPhys	*20*	
41	Disengage patient and reposition	L152A	MedPhys	*12*	
42	Reset plugs	L152A	MedPhys	*4*	
43	Complete treatment and documentation	L152A	MedPhys	*5*	
44	TOTAL MEDICAL PHYSICIST	L152A	MedPhys	185	
45	Assist physician in performing procedure & provide monitoring for CS	L051A	RN	45	
46	**Post-Service**				
47	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	30	
48	Clean room/equipment by physician staff	L037D	RN/LPN.MA	3	
49	Clean Scope				
50	Clean Surgical Instrument Package				
51	Complete diagnostic forms, lab & X-ray requisitions				
52	Review/read X-ray, lab, and pathology reports				
53	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
54	Discharge day management				
55	Other Clinical Activity (please specify)				
56	**End: Patient leaves office**				
57	POST-SERVICE Period				
58	**Start: Patient leaves office/facility**				
59	Conduct phone calls/call in prescriptions	L037D	RN/LPN MA	3	3
60	*Office visits: None*				
67	*Total Office Visit Time*			0	0
68	Other Activity (please specify)				
69	**End: with last office visit before end of global period**				

	A	B	C	D	E
1				CPT Code 77371	
2	**Meeting Date: April 2009** **AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Radiation treatment delivery, stereotactic radiosurgery (SRS); multi source Cobalt 60 based**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
70	MEDICAL SUPPLIES		Unit		
71	pack, conscious sedation	SA044		1	
72	drape, non-sterile, sheet 40in x 60in	SB006		1	
73	underpad 2ft x 3ft (Chux)	SB044		3	
74	gloves, non-sterile	SB022		4	
75	sodium chloride 0.9% inj (250-1000ml uou)	SH067		1	
76	syringe 10-12ml	SC052		2	
77	Acetaminophen	SK020		1	
78	straws/cups	SL037		2	
79	medicine cup	SL037		2	
80	basin, emesis	SJ010		1	
81	Nasal cannula	SD100		1	
82	bacitracin oint (0.9gm uou)	SJ007		4	
83	bandage, Kling, sterile 4in	SG020		1	
84	tape, surgical paper 1in (Micropore)	SG079		10	
85	bandage, strip 0.75in x 3in (Bandaid)	SG021		1	
86	2x2 gauze	SG053		1	
87	Enzymatic cleaner	SM015		1	
88	Equipment		Session		
89	Gammaknife			1	
90	Radioactive Source			1	
91	stretcher	EF018		1	
92	x-ray view box, 4 panel	ER067		1	
93	film processor, x-omat (m6B)	ED027		1	
94	blood pressure monitor, ambulatory, w-battery charger	EQ269		1	
95	pulse oximeter w-printer	EQ211		1	
96	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		1	
97	IV infusion pump	EQ032		1	
98	oxygen system, portable	EQ192		1	
99					

ASTRO

TARGETING CANCER CARE

March 31, 2009

William Rich, MD
Chair, RVS Update Committee
American Medical Association
Department of Physician Payment Policy and Systems
515 N. State Street
Chicago, IL 60654

Re: CPT Code 77371 PE Recommendations

Attached are the revised PE recommendations for CPT Code 77371. In response to public comments received (not from ASTRO) CMS asked ASTRO to develop revised PE recommendations for this CPT code. In the MFS Final Rule for 2009 CMS discussed comments received. Commenters stated that:

> *The PE RVUs listed in Addendum B for CPT 77371 were exceptionally inadequate. The commenters also stated that they believe the direct PE inputs are incorrect since the cost data they had gathered from other facility providers of this stereotactic radiosurgery (SRS) service included extra clinical labor time due to Nuclear Regulatory Commission (NRC) requirements for both the physicist and the registered nurse. In addition, they disagreed with our decision to treat the Cobalt 60 radiation source (recommended by the AMA RUC as a 1-month renewable equipment item) as an indirect PE cost in the CY 2007 PFS final rule with comment period.*
> *(Federal Register / Vol. 73, No. 224 / Wednesday, November 19, 2008 / Rules and Regulations p.69737)*

CMS asked the AMA RUC to review the direct PE inputs for this code in light of these comments. In the interim, they believed the commenters raised sufficient questions regarding the propriety of the direct PE inputs and PE RVUs established for this new code in 2007 to warrant contractor pricing for CPT 77371 for CY 2009. The Medicare Part B Claims data for 2007 reports 50 claims, while the OPPS data has for 2007 reported approximately 4,000 claims.

Historical Information

Original PEAC Submission (Sept 2005) = 373 minutes
Approved PEAC (Sept 2005) = 234 minutes *(attachment)*
Current IRSA Request = 730 minutes (+496 minutes) *(attachment)*
Current Recommendations = 333 minutes (+99 minutes) *(attachment)*

Clinical Time

- Facility Time: No Changes
- Non Facility Time: Pre & Post No Changes

AMERICAN SOCIETY FOR RADIATION ONCOLOGY
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www.astro.org · www.rtanswers.org

- Non Facility: Intra Service Changes
    1. Total Intra Time increased from 222 minutes to 321 minutes
    2. Eliminated the RT and reassigned remaining activities to Medical Physics
    3. Changed post monitor time back to 30 minutes from 20 minutes
    4. Changed several nurse designated activities from RN/LPN/MA to RN

Supplies

Changes have been made to the supply list. We deleted several items related to (1) x-ray films and (2) starting the IV. We added miscellaneous supplies, such as the syringes (for administering meds through the IV during treatment), topical antibiotic, gauze, etc.

Equipment

Minor changes have been made to the equipment list. We added a stretcher, blood pressure monitor and the conscious sedation equipment items. We will contact IRSA representatives and requested that they provide copies of invoices to CMS for the updated prices on the Gamma Knife system and the Cobalt 60 sources.

The major issue that remains with the equipment list is the cost of the radioactive source(s). CMS policy currently treats the radioactive source for CPT Code 77371 as an indirect cost *(Federal Register / Vol. 71, No. 231 / Friday, December 1, 2006 / Rules and Regulations p.69747.)*

These recommendations are also supported by AANS. Please let us know if you have any questions.

Regards,

Najeeb Mohideen, MD
ASTRO RUC Advisor

Michael Kuettel, MD, MBA, PhD
ASTRO RUC Advisor Alternate

Attachments

cc: Sherry Smith
Roseanne Fischoff
John A Wilson, MD
Cathy Hill
Trisha Crishock

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor: **Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multisource Cobalt 60 based. (For Radiation treatment management, use 77432)**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

ASTRO developed these PE recommendations by Consensus Panel. The Panel had several radiation oncologists and medical physicists, including SRS experts. The Panel reviewed the historical information for CPT Code 77371 including the comments received by CMS. The recommendations were also discussed with AANS.

Please describe the clinical activities of your staff:

The head-frame has been previously attached by the neurosurgeon, as described in CPT Code(s) 61796 or 61798.

Pre-Service Clinical Labor Activities:
The pre-service period includes time allocated for: completing pre-service diagnostic and referral forms; coordinating pre procedure services; for the facility setting, scheduling the service; and finally providing education and obtaining the patient consent.

Intra-Service Clinical Labor Activities:
When the patient arrives at the office for their treatment, service requires the involvement of the Oncology Nurse, and the Medical Physicist (in addition to the Doctor). The physicist has acquired the data needed for the particular patient, and enters this data into the treatment machine. Once the data is entered, the nurse leads the patient into the treatment room.

The patient is taken into the treatment room, and the physician and the physicist together review the original and new films, the prescription, and the data that was entered into the treatment machine. To ensure the accuracy of the treatment setup, the physicist then verifies the stereotactic isocenter using the Winston-Lutz phantom test. While this is occurring, the nurse is assisting the patient in getting comfortable and then takes the patients vital signs, such as their temperature, blood pressure, pulse, and respiration. Once these vitals have been documented, the patient is then placed on the treatment couch. The nurse and physicist position the patient with the appropriate immobilization system, and the head ring is calibrated to the stereotactic isocenter and the test that were performed to validate the patient setup. Once the patient is then positioned, the nurse then inserts the IV for the patient, and the SRS treatment delivery begins.

During the treatment delivery, the nurse and physicist are in the room at all times to monitor the delivery procedure. The nurse will monitor the oxygen (O_2) saturation of the patient, as well as to track the shots of radiation that are given.

Post-Service Clinical Labor Activities:
After the last segment of radiation is given, the patient is taken out of the immobilization apparatus, and the neurosurgeon removes the head frame, as described in CPT Code(s) 61796, 61797, 61798 or 61799. The patient is then taken into a separate room for recovery for up to two hours. While the patient is resting, the nurse cleans the room and any of the materials that may have been used during the procedure, monitors vital signs, and provides post treatment education and schedules the follow up appointments.

Phone calls are made by the nurse to follow up on side effects and phone in prescriptions.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
CMS Request

April 2009

End Stage Renal Disease Practice Expense and Physician Time Recommendation

CMS requested in the 2009 *Final Rule*, that the RUC review the practice expense inputs associated with the end stage renal disease (ESRD) codes to ensure that they accurately reflect the typical direct resources required to perform these services and to review the physician time for 90960 and 90961.

Practice Expense Clinical Labor Time

The specialty society convened an expert panel to review the direct practice expense clinical labor time for the adult and pediatric ESRD codes. The specialty panel agreed that 42 minutes of clinical staff time, for all of the varied and unpredictable services to a typical patient with 6 co-morbid conditions and on more than 7 drugs over the course of a month, was not sufficient to reflect the clinical staff activities performed in support of monthly dialysis care. The specialty panel determined that an additional 24 minutes of clinical staff pre-service time for the pediatric codes and 18 additional minutes for the adult codes, would accurately reflect the services provided over an entire month. The clinical activities that the expert panel believed had been under-represented were:

(1) unscheduled follow up phone calls and prescription drug review-6 minutes (12 minutes for pediatrics patients)
(2) lab and x-ray review-3 minutes
(3) evaluation of dialysis access problems-3 minutes
(4) transplant evaluation-1 minute
(5) multidisciplinary care team meetings-5 minutes

By adding these clinical labor time increments both the pediatric and adult ESRD monthly codes would have a total of 60 minutes of clinical labor time. The RUC agreed with the addition of this clinical labor time. In addition, this monthly time of 60 minutes was recommended to be applied to all of the codes in the code family, including the home dialysis codes (CPT codes 90963-90966), and proportionately to the daily dialysis codes (CPT codes 90967-90970), the values for which have been historically based on 1/30th of the monthly code value.

The RUC therefore recommends that the monthly outpatient dialysis codes (CPT codes 90951-90966), representing both in-center and home dialysis care, be assigned an additional 24 minutes of clinical staff time per code for the pediatric codes and 18 minutes of clinical staff time per code for the adult codes, and that this revision also be applied proportionately to the daily dialysis service codes (CPT codes 90967-90970) to reflect the clinical staff activities currently necessary to provide services to the typical adult and pediatric ESRD patients. Therefore, the total clinical staff time for all monthly codes should now be 60 minutes.

Physician Time for CPT code 90960 and 90961

Upon reviewing the physician time for CPT codes 90960 and 90961, the RUC concurred with CMS that for practice expense purposes, the physician time needed additional review. The specialty noted that the unit level code, 90962, was provided with 38 minutes of physician time for Care Plan Oversight (from procedure code G0182), while the services with increased physician visits and activity, 90960 and 90961, were not. The RUC agreed that even though the physician time recommendations for codes 90960 and 90961 are based on a higher number of building blocks, the degree of care plan oversight activities for these services is no less than that for the unit level code and, for practice expense purposes, were not captured by the office visit building blocks currently comprising the recommendations for these services. **The RUC recommends that CPT codes 90960 and 90961 be assigned an additional 38 minutes of physician time for practice expense purposes to reflect the care plan oversight activities currently necessary to provide services to the typical adult ESRD patient. The new total time for CPT code 90960 is 128 minutes and 113 minutes for 90961.**

1915

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
90951	End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	Clinical Labor Recommendation
90952	with 2-3 face-to-face physician visits per month	XXX	Clinical Labor Recommendation
90953	with 1 face-to-face physician visit per month	XXX	Clinical Labor Recommendation

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
90954	End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	Clinical Labor Recommendation
90955	with 2-3 face-to-face physician visits per month	XXX	Clinical Labor Recommendation
90956	with 1 face-to-face physician visit per month	XXX	Clinical Labor Recommendation
90957	End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	XXX	Clinical Labor Recommendation
90958	with 2-3 face-to-face physician visits per month	XXX	Clinical Labor Recommendation
90959	with 1 face-to-face physician visit per month	XXX	Clinical Labor Recommendation
90960	End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month	XXX	Physician Time and Clinical Labor Recommendation
90961	with 2-3 face-to-face physician visits per month	XXX	Physician Time and Clinical Labor Recommendation
90962	with 1 face-to-face physician visit per month	XXX	Clinical Labor Recommendation

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	Clinical Labor Recommendation
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	Clinical Labor Recommendation
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	XXX	Clinical Labor Recommendation
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over	XXX	Clinical Labor Recommendation

TAB 6-ESRD-RELATED SERVICES

March 31, 2009

To: RUC Members

From: Robert J. Kossmann, M.D., RUC Advisor,
Renal Physicians Association

Eileen D. Brewer, M.D., RUC Presenter,
American Society of Pediatric Nephrology

Richard J. Hamburger. M.D., RUC Presenter,
Renal Physicians Association

Re: Discussion of Recommendations for Practice Expense Value Clinical Staff Times for Monthly Adult and Pediatric Dialysis Services, and for Practice Expense Physician Times for CPT Codes 90960 and 90961

Introduction

This document is a proposal for the revaluation of the practice expense clinical staff times for the monthly dialysis services for both adult and pediatric patients, and for the physician times associated with two of the adult monthly dialysis codes, CPT code 90960 (adult monthly dialysis, four or more visits) and CPT code 90961 (adult monthly dialysis, 2-3 visits). This revaluation was prompted by a request from CMS as outlined in the final rule for the 2009 Medicare Physician Fee Schedule.

By way of review, these codes were originally valued at the February 2008 RUC meeting based on the use of a survey instrument vetted by the RUC Research Subcommittee and approved by the full RUC at the September 2007 RUC Meeting which attempted to use the 90 day global surgery form for obtaining a month's worth of work by the nephrologist caring for an ESRD patient. This instrument required the reporting of the physician separately from the physician extender services at the 85 percentile even though the physician extender did not bill independently and their work was part of that physicians bundle of services. The performance of the survey and the development of proposed values proved to be extremely difficult, due in most part to the unique nature of the monthly dialysis services themselves. This is a capitated payment where every patient receives a unique variety of services. Rather than seeking to determine the work associated with a single episode of care, for these monthly codes survey respondents had to account for the multiplicity of services and diversity of physician activity, as well as the attendant practice costs, necessary to provide the variable and unpredictable mix of services associated with appropriate care for an ESRD patient, over a month's time. The typical adult patient is over 65 years of age and has diabetes, hypertension and vascular disease as well as ESRD. The survey instrument approved by the RUC did seek to

provide an appropriate mechanism for capturing these activities and expenses, but challenges remained nonetheless.

These challenges were exacerbated on the pediatric side by the finite census of pediatric nephrologists in the U.S., and the small number of actual billed codes in the <2 year old and 2-11 year old age group, resulting in a limited survey response. It should be noted that children account for less than 2% of all ESRD patients, and thus the Medicare claims utilization for services provided to pediatric dialysis patients is of a similarly limited nature.

This document will discuss typical ESRD patients in aggregate, provide historical background on how the entire family of dialysis codes arrived at their current structure and were valued at the February 2008 RUC meeting, and offer recommendations for the reconsidering the clinical staff times for the entire code family, and the physician times for CPT codes 90960 and 90961.

ESRD Patients in Aggregate

Typically, adult ESRD patients suffer from a series of chronic illnesses in addition to their kidney disease, including Type II diabetes mellitus, vascular disease, and hypertension. There is an approximate 19% annual mortality rate among adult ESRD patients. The typical adult ESRD patient has 2.0 hospital admissions per year, or on average 14 hospitalization days per year.

Pediatric ESRD patients present unique challenges that impact the physician work and practice expense involved in providing their treatment. Children who require chronic dialysis have a wide spectrum of underlying diseases, including congenital renal anomalies present since birth, like renal dysplasia and obstructive uropathy, or rare hereditary diseases that present early in life, such as primary hyperoxaluria, cystinosis and autosomal recessive polycystic kidney disease, or rare acquired glomerular diseases, such as nephrotic syndrome from focal glomerulosclerosis, membranoproliferative GN, rapidly progressive GN, IgA nephropathy or hemolytic uremic syndrome. Less than 3% have underlying diabetes or hypertension as the cause of their ESRD. Before reaching ESRD, most of the children have long standing chronic kidney disease that has disrupted growth and development, compromised bone health and resulted in behavioral and learning problems and family dysfunction. Those with congenital anomalies have required multiple urologic surgeries. Many of the children with disease since infancy also have other organ failure, such as hypoplastic lung disease, congenital hepatic fibrosis, cardiomyopathy and spina bifida. Concomitant deafness and seizure disorders are common. The pediatric ESRD dialysis population is not just a healthy group of children who suddenly developed renal failure and were otherwise normal.

Infants requiring chronic dialysis present the biggest challenge and typically are the sickest with a disease burden that includes catheter access problems, renal osteodystrophy, anemia, acidosis, growth failure, developmental delay, anorexia and feeding problems, family dysfunction related to a technologically dependent infant, modified childhood

immunizations, and polypharmacy (>7 medications) and require more intensive physician services. Older children and adolescents will have similar disease burdens along with varying, age-dependent stages of behavioral issues. Infants are hospitalized an average of 3 times per year, and older children and adolescents between 2-2.5 times a year. Average yearly hospitalization days are 12 days for hemodialysis and 14 days for peritoneal dialysis patients. The most common causes of hospitalization are infection (including peritonitis and dialysis catheter line sepsis), malnutrition, fluid overload and dialysis access problems. Annual mortality for pediatric dialysis patients is about 100 times higher than for the general pediatric population, and the probability of 5-year survival for children on dialysis is only 0.81.

Historical Background of MCP Valuation—Bulleted Summary

- In the December 8, 1994 issue of the *Federal Register* setting forth the Medicare Fee Schedule for 1995, then-HCFA established a process for development of work values for the Monthly Capitated Payment (MCP) for ESRD services that utilized different office visit codes as "building blocks" for the MCP.

- HCFA noted that the mix of the "visit code building blocks most appropriately represents the typical mix of encounters with the ESRD patient who is dialyzed in an ESRD facility and accounts for the service intensity and complexity of decision-making and the pre-service and post-service work for a month's care of a typical dialysis patient."

- A panel of carrier medical directors (CMDs) that included a representative of the RUC determined that the appropriate building block mix for adults was four counts of the work RVUs for CPT code 99212 and two counts of the work RVUs for CPT code 99214 (representing a reduction from the original RUC recommendations). This resulted in a work RVU of 3.09 for CPT code 90921, rather than the higher RUC proposed bundle 5.24 work RVUs. The same building blocks were used for the pediatric codes, except with proportionally higher work values for infants, older children and adolescents (e.g. for <2 year old, 16 counts of CPT 99212 and 4 counts of CPT 99214 work RVUs; for 2-11 year old, 0.73x <2 year old CPT work RVUs; for 12-19 year old, 0.6x<2 year old CPT work RVUs).

- These values remained in place until the rulemaking cycle for the 2004 Medicare Fee Schedule, in which now-CMS established a stratified MCP payment system based on the number of face-to-face interactions between the MCP physician and the ESRD patient.

- This system established a mid-level adult MCP code (G-0318) based on the previous adult MCP code (CPT code 90921) and representing 2-3 physician-ESRD patient interactions, and provided additional RVUs for 4 physician-ESRD patient interactions (G-0317) and fewer RVUs for 1 physician-ESRD patient interaction (G-0319). This methodology was derived to be budget neutral rather

than fact based and also was applied to the pediatric series of monthly dialysis services, codes G-0308-G0310 for patients less than two years of age, codes G-0311-G0313 for patients between the ages of two and eleven, and codes G-0314-G0316 for patients ages twelve to nineteen. A new set of codes (G-0320-0323) were created for home dialysis and not based on actual number of face-to-face visits, but determined to be a level of RVUs equal to the 2-3 visit G-codes by age group.

- When the Five-Year Review of E&M Codes increased the work RVUs for selected E&M codes in 2006, the E&M value increases were applied to all global surgical packages with E&M elements. These increases were however not applied to the MCP family of ESRD MCP codes. As a result, RPA petitioned CMS to apply these increases in the MCP building block codes to the current MCP as part of its comments on the 2007 Medicare Fee Schedule Proposed Rule.

- RPA's recommendation called for CMS to revise the ESRD MCP codes based on the previously determined building blocks and using the mid-level code (G-0318) as an anchor since that code most closely approximated the previous adult MCP code (CPT code 90921), with the same methodology being applied to the pediatric series of monthly dialysis services. This recommendation would have increased the work RVUs for the adult codes by approximately 9% (from a WRVU of 4.24 for G-0318 to a WRVU of 4.64), and for the pediatric codes by approximately 21% (from a WRVU of 10.61 for G-0309 to a WRVU of 12.88). However, the recommendation was not accepted and CMS referred RPA to the RUC for valuation of the services associated with the ESRD MCP G-codes.

- In September 2007 the family of monthly dialysis codes was presented to the CPT Editorial Panel, and that proposal was accepted and referred to the RUC for valuation.

- In February 2008 the RUC valued the services for physician work and practice expense for the entire outpatient dialysis code family. The values generated by the RUC are available elsewhere in this tab.

- When CMS released the final rule for the 2009 Medicare Fee Schedule, it requested the RUC to review elements of the practice expense values that were developed by the RUC and included in the RUC recommendations sent to CMS in May 2008. Specifically, the Agency requested review of the clinical staff times for CPT codes 90951-90970, as well as the physician times (for practice expense purposes) of CPT codes 90960 and 90961.

- During the February 2009 RUC meeting, RPA/ASPN representatives proposed that 18 minutes of additional clinical staff time be added to the 42 minutes of clinical staff time assigned to the codes during the original review. These original 42 minutes were based on a direct crosswalk from the 36 minutes of

RN/LPN/MTA time assigned to CPT code 99375 (Care Plan Oversight) and six minutes of RN/LPN/MTA time for two phone calls.

- RPA/ASPN representatives also noted the structural similarity between the ESRD monthly services and activities associated with the recently valued medical home demonstration codes. The Tier 3 medical home patient was assigned 80 minutes of clinical staff time, and the Tier 2 medical home patient was assigned 66 minutes of clinical staff time, for treatment of patient populations generally with fewer co-morbid conditions and on fewer prescriptions.

- The RUC PE Subcommittee generally agreed that approximately 16 to 18 minutes of additional time seemed appropriate but referred RPA and ASPN to an informal facilitation group for development of a more structured proposal.

- The informal facilitation group determined that since using three different methodologies for determining the clinical staff time for the monthly codes brought the total to a range of 58-60 minutes, the correct value is likely within that range. The three methodologies were: (1) the PEAC methodology from 2002 that included CPT code 99211 as a building block for the codes at that time and would bring the total of clinical staff time for these services from 42 minutes to 58 minutes; (2) use of the clinical staff times from 99375, two phone calls, and 99211 (36 + 6 + 16 = 58 minutes); and (3) the use of the pre-service clinical staff time from 99375, two phone calls, and the staff time from 99213 (18 + 6 + 36 = 60 minutes). All three of these methodologies were transcribed into an Excel spreadsheet for distribution among the PE Subcommittee.

- At the subsequent meeting of the PE Subcommittee, once again it became apparent that while the subcommittee believed the 58-60 minute range was reasonable and appropriate, evaluating the proposal was difficult as the minutes were not indicated on the standard RUC PE form. Further, PE subcommittee members questioned the urgency of pursuing this code proposal at this meeting, noting that it might be better for RPA/ASPN to revise its proposal and pursue it at the April 2009 RUC meeting.

- CMS staff also underscored to RPA/ASPN representatives the fundamental role that physician times play in the development of practice expense values, and urged the subspecialties to review the physician times assigned to CPT codes 90960 and 90961 to ensure that the practice expense associated with these services is appropriately captured in the revised values.

Discussion of Practice Expense Relative Value Unit Recommendations

Clinical Staff Times for Outpatient Dialysis Services

As noted above, subsequent to CMS' request for review of the PE direct inputs for the monthly and daily dialysis codes, an RPA/ASPN expert panel evaluated the clinical staff

times assigned during the February 2008, and concurred with CMS that the inputs merited review.

Specifically, the expert panel believed that the 42 minutes of clinical staff time, again for a month's worth of varied and unpredictable services to a typical patient with 6 co-morbid conditions and on more than 7 drugs, was not sufficient to reflect the clinical staff activities performed in support of monthly dialysis care. The panel determined that with an additional 18 minutes of clinical staff pre-service time, the inputs would accurately reflect the month's services. Among the clinical activities that the expert panel believed had been under-represented: (1) unscheduled follow up phone calls and prescription drug review-6 minutes; (2) lab and x-ray review-3 minutes; (3) evaluation of dialysis access problems-3 minutes; (4) transplant evaluation-1 minute; and (5) multidisciplinary care team meetings-5 minutes. These values are indicated on the RUC PE form appended to this document.

The RPA/ASPN expert panel believes that these 18 minutes of additional clinical staff time should be applied to all of the monthly codes (both adult and pediatric) in the outpatient dialysis service family. It is our strong belief that it is appropriate that the PE be constant across the groupings of codes by age category, since all patients, regardless of the number of physician work/face-to-face encounters, require a similar baseline level of clinical staff support.

Since it is our belief that the recommendation above should apply to all of the codes in the code family, they thus should apply to the home dialysis codes (CPT codes 90963-90966), and proportionately to the daily dialysis codes (CPT codes 90967-90970), the values for which have been historically based on $1/30^{th}$ of the monthly code value.

RPA/ASPN therefore recommend that the monthly outpatient dialysis codes (CPT codes 90951-90966), representing both in-center and home dialysis care, be assigned an additional 18 minutes of clinical staff time per code, and that this revision also be applied proportionately to the daily dialysis service codes (CPT codes 90967-90970) to reflect the clinical staff activities currently necessary to provide services to the typical adult and pediatric ESRD patients.

Practice Expense Physician Times for CPT code 90960 and 90961

Upon reviewing the physician times for CPT codes 90960 and 90961, the RPA/ASPN expert panel again concurs with CMS that for practice expense purposes, the physician times merit additional review. Please recall that for the adult monthly dialysis codes, the RUC determined that a building block methodology should be utilized to evaluate these codes and accordingly made the following recommendations:

90960 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month*

1 – 99213 Office/Outpt Visit, Est	0.92	15 minutes

3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
90960	**5.18 RVUs**	**90 minutes**

90961 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month*

3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
90961	**4.26 RVUs**	**75 minutes**

90962 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 1 face-to-face physician visit per month*

1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
90962	**3.15 RVUs**	**63 minutes**

In reviewing the recommendations, the RPA/ASPN expert panel in retrospect noted the fact that the unit level code, 90962, was provided with 38 minutes of physician time for Care Plan Oversight (from procedure code G0182), while the services with increased physician visits and activity, 90960 and 90961, were not. It is RPA/ASPN's belief that even though the recommendations for codes 90960 and 90961 are based on a higher number of building blocks, the degree of care plan oversight activities for these services is no less than that for the unit level code and, for practice expense purposes, are not captured by the office visit building blocks currently comprising the recommendations for these services.

RPA therefore recommends that CPT codes 90960 and 90961 be assigned an additional 38 minutes of physician time for practice expense purposes to reflect the care plan oversight activities currently necessary to provide services to the typical adult ESRD patient.

	A	B	C	D	E	F	G	H	I	J	K
1				90960		90961		90962		90966	
2	**ESRD Services 20 Years of Age or more**			End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month		End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2-3 face-to-face physician visits per month		End stage renal disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month		End stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over	
3	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD										
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	PRE SERVICE										
10	Start: Following visit when decision for surgery or procedure made										
11	Coordination of care (crosswalked from 99375)	L037D	RN/LPN/MTA	36	36	36	36	36	36	36	36
12	Follow-up insurance, prescriptions, amd Medicare D	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
13	Triage of acute symptoms/intercurrent illness	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
14	Other Clinical Activity: coordination of home services (oxygen, visiting nurse, PT/OT, etc.)	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
15	Other Clinical Activity:coordination of referral to endocrinologist, podiatrist, cardiologist, gastroenterologist, etc.	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
16	End:When patient enters office/facility for surgery/procedure										
17	SERVICE PERIOD										
18	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
19	Intra-service										
20											
21	Post-Service										
22	End: Patient leaves office										
23	POST SERVICE Period										
24	Start: Patient leaves office/facility										
33	Phone calls	L037D									
36	End: with last office visit before end of global period										

99375

ESRD Services Under 2 Years of age			90951 End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month		90952 End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month		90953 End stage renal disease (ESRD) related services during the course of treatment, for patients under 2 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month		90963 End stage renal disease (ESRD) related services for home dialysis per full month, for patients under 2 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	
LOCATION	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
GLOBAL PERIOD										
TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	6.0	6.0	6.0	6.0	0.0	0.0	0.0	0.0
PRE-SERVICE										
Start: Following visit when decision for surgery or procedure made										
Coordination of care (crosswalked from 99375	L037D	RN/LPN/MTA	36	36	36	36	36	36	36	36
Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	6	6	carrier priced	carrier priced	carrier priced	carrier priced	6	6
Triage of acute symptoms/intercurrent illness	L037D	RN/LPN/MTA	9	9	carrier priced	carrier priced	carrier priced	carrier priced	9	9
Other Clinical Activity: coordination of home services (feeding pump and supplies PT/OT, etc.)	L037D	RN/LPN/MTA	6	6	carrier priced	carrier priced	carrier priced	carrier priced	6	6
Other Clinical Activity: coordination of referral to pediatric urologist, pediatric surgeon, developmental specialist .	L037D	RN/LPN/MTA	3	3	carrier priced	carrier priced	carrier priced	carrier priced	3	3
End:When patient enters office/facility for surgery/procedure										
SERVICE PERIOD										
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
Intra-service										
Post-Service										
End: Patient leaves office										
POST-SERVICE Period										
Start: Patient leaves office/facility										
Conduct phone calls/call in prescriptions										
Phone calls										
Total Office Visit Time										
Other Activity (please specify)										
End: with last office visit before end of global period										

ESRD Services 2 - 11 Years of Age			90954 End stage renal disease (ESRD) related services during the course of treatment, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month		90955 End stage renal disease (ESRD) related services during the course of treatment, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month		90956 End stage renal disease (ESRD) related services during the course of treatment, for patients 2-11 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to face physician visit per month		90964 End stage renal disease (ESRD) related services for home dialysis per full month, 2-11 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	
LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
GLOBAL PERIOD										
TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
TOTAL PRE-SERV CLINICAL LABOR TI	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PRE-SERVICE										
Start: Following visit when decision for surgery or procedure made										
Coordination of care (crosswalked from 99375	L037D	RN/LPN/MTA	36	36	36	36	36	36	36	36
Follow-up insuance, prescriptions, and Medicare D	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
Triage of acute symptoms/intercurrent illness	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
Other Clinical Activity: coordination of home and school services (feeding pump and supplies, entry early child development program, adjust school schedule for dialysis, school medication forms, special diet for school, behavioral problems, etc.)	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
Other Clinical Activity:coordination of referral to pediatric urologist, pediatric surgeon, developmental specialist, etc.	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3
Other Activity: education and counseling, including growth hormone	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3
End:When patient enters office/facility for surgery/procedure										
SERVICE PERIOD										
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
Intra-service										
Post-Service										
End: Patient leaves office										
POST-SERVICE PERIOD										
Start: Patient leaves office/facility										
Conduct phone calls/call in prescriptions										
Office visits: None										
Phone calls										
Total Office Visit Time										
Other Activity specify)										
End: with las visit before end of global period										

ESRD Services 12 - 19 Years of Age			90957 End stage renal disease (ESRD) related services during the course of treatment, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month		90958 End stage renal disease (ESRD) related services during the course of treatment, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month		90959 End stage renal disease (ESRD) related services during the course of treatment, for patients 12-19 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month		90965 End stage renal disease (ESRD) related services for home dialysis per full month, 12-19 years of age, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	
LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
GLOBAL PERIOD										
TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PRE SERVICE										
Start: Following visit when decision for surgery or procedure made										
Coordination of care (crosswalked from 99375	L037D	RN/LPN/MTA	36	36	36	36	36	36	36	36
Follow-up insurance, prescriptions and Medicare D	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
Triage of acute symptoms/intercurrent illness	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
Other Clinical Activity: coordination of home and school services (feeding pump and supplies, entry early child development program, adjust school schedule for dialysis, school medication forms, special diet for school, behavioral problems, etc.)	L037D	RN/LPN/MTA	6	6	6	6	6	6	6	6
Other Clinical Activity:coordination of referral to pediatric urologist, pediatric surgeon, psychologist, orthopedic surgeon, etc.	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3
Other Activity: education and counseling, including growth hormone and transitioning for adult care	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3
End:When patient enters office/facility for surgery/procedure										
SERVICE PERIOD										
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
Intra-service										
Post-Service										
End: Patient leaves office										
POST-SERVICE Period										
Start: Patient leaves office/facility										
Conduct phone calls/call in prescriptions										
Office visits: None										
Phone calls										
Total Office Visit Time										
Other Activity (please specify)										
End: with last office visit before end of global period										
MEDICAL SUPPLIES		Unit								
Equipment										

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
CMS Request

February 2009

Speech-Language Pathology

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech-language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech-language pathologists will be able to bill Medicare independently as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation, speech-language pathology services be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech-language pathology codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech-language pathology codes over the course of the CPT 2010 and CPT 2011 cycles.

1930

At the February 2009 meeting, the RUC reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function.*

92597

The RUC reviewed the survey data from 31 speech-language pathologists and 5 otolaryngologists for code 92597. The survey data between both specialties was comparable. The specialty societies confirmed that this service is not included in the 090-day global period of performing a laryngectomy 31360 *Laryngectomy; total, without radical neck dissection* or 31365 *Laryngectomy; total, with radical neck dissection* which does not involve placing a fistula or dilating a stoma. However, the specialty societies recommended and the RUC agreed that the survey respondents slightly overestimated the time required to perform this service. Therefore, the RUC recommends pre-service package 5-Non-facility procedure without sedation/anesthesia care (7 minutes evaluation), a reduction of the intra-service time by 15 minutes to 40 minutes, and the immediate post-service time by 2 minutes to 13 minutes. The RUC also compared 92597 to code 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-, 30 minutes intra- and 8 minutes immediate post-service time) and determined that 92597 required slightly more work and time to perform than 97001. The RUC determined that the decrease in physician time and survey median work RVU of 1.48 appropriately reflects the work required to

perform this service. **The RUC recommends a work RVU of 1.48 for code 92597.**

92610

The RUC reviewed the survey data from 125 speech-language pathologists and 5 otolaryngologists for code 92610. The specialty society recommended and the RUC agreed that the survey respondents slightly overestimated the time required to perform this service. Therefore, the RUC recommends pre-service package 5-Procedure without sedation/anesthesia care (7 minutes evaluation), a reduction in the intra-service time by 10 minutes to 35 minutes, and a reduction of the immediate post-service time by 5 minutes to 10 minutes. The RUC also compared 92610 to codes 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-, 30 minutes intra- and 8 minutes immediate post-service time) and 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60 and 3minute pre-time, 20 minutes intra-time and 5 minutes immediate post service time). The RUC determined that 92610 required slightly more work and time to perform than 97001 and required approximately double that of the time and work required for 92557. The RUC determined that the decrease in physician time and surveyed 25th percentile work RVU of 1.30 appropriately reflects the work required to perform this service. **The RUC recommends a work RVU of 1.30 for code 92610.**

1931

Practice Expense

The RUC recommends removing the associated speech-language pathologists' time from the direct practice expense inputs, as all physician and speech-language pathologist work is captured in the work RVU. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

PLI

The RUC recommends that code 92597 and 92610 be crosswalked to 92557.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	XXX	1.48
92610	Evaluation of oral and pharyngeal swallowing function	XXX	1.30

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92597 Tracking Number Specialty Society Recommended RVU: **1.48**

Global Period: XXX RUC Recommended RVU: **1.48**

CPT Descriptor: Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male diagnosed with laryngeal carcinoma required a total laryngectomy and bilateral neck dissection. As part of the primary laryngectomy surgery, the surgeon created a tracheoesophageal fistula to permit alaryngeal communications via a voice prosthesis. Patient is evaluated for use of and fitted with a tracheoesophageal voice prosthesis.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review medical records, assemble materials for removal of sutures and for measurement, fitting, and placement of tracheoesophageal prosthesis

Description of Intra-Service Work: Instruct patient in procedure, examine and clean puncture site, remove suture holding the stent in place and remove catheter, dilate puncture site, prepare prosthesis for insertion, size the puncture, fit prosthesis, verify placement, instruct patient in use of prosthesis and verify patient can phonate and speak in sentences

Description of Post-Service Work: Discuss care, precautions, and cleaning of prosthesis with patient/family, write report, communicate with referring physician, write orders for patient supplies

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	Jane Dillon, MD, Robert Fifer, PhD, Dee Adams Nikjeh, PhD				
Specialty(s):	Speech-Language Pathology and Otolaryngology				
CPT Code:	92597				
Sample Size:	148	**Resp N:**	36	**Response:** 24.3 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.75	**11.00**	30.00	80.00
Survey RVW:	0.62	1.26	**1.48**	1.76	3.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**55.00**	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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(3ɛ,, 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92597	**Recommended Physician Work RVU: 1.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**13.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
97001	XXX	1.20	**RUC Time**	1,500,000

CPT Descriptor 1 Physical therapy evaluation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90806	XXX	1.86	**RUC Time**	5,500,000

CPT Descriptor 2 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 38.8 %

TIME ESTIMATES (Median)	CPT Code: 92597	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	7.00	5.00	
Median Intra-Service Time	40.00	25.00	
Median Immediate Post-service Time	13.00	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**	**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	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	5.00
Physical effort required	4.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.00
Outcome depends on the skill and judgment of physician	4.50	4.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	5.00	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 usea IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Speech-Language-Hearing Association (ASHA) conducted a survey of speech language pathologists (SLPs) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) also surveyed this code. A

total of 36 complete responses were received (31 from ASHA and 5 from AAO-HNS). This is the first set of work surveys which SLPs have completed so there is an absence of well-established reference codes for SLP services. (Currently, SLP time is valued only through the practice expense component.) The most frequently selected reference code was Code 99214, established office visit, which has an RVW of 1.42 and pre, intra and post time of 5, 25, and 10 minutes.

We are recommending an RVW of 1.48 based on the combined median survey data. We are also recommending professional time of 10 minutes pre, 40 minutes intra and 13 minutes post time. The pre, intra, and post times recommended are lower than the medians. This results in an IWPUT of about 0.024 which is much less than one-half of the IWPUT for 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)

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 Speech-Language Pathology How often? Sometimes

Specialty Otolaryngology 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. We do not have reliable frequency data for this code since it is primarily performed in hospital settings which are billed to intermediaries. Therefore, the frequency data for this code in the RUC data base only reflects a fraction of the total billings. There were 1,727 total billings in the RUC data base mostly performed in the office setting. We estimate that at least twice that were performed on Medicare patients in the hospital setting resulting in a total volume of about 5,100 with most done on Medicare patients. We estimate that perhaps 10,000 are the total volume of procedures.

Specialty Speech-Language Pathology Frequency 8000 Percentage 80.00 %

Specialty Otolaryngology Frequency 2000 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? 5100 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We do not have reliable frequency data for this code since it is primarily performed in hospital settings which are billed to intermediaries. Therefore, the frequency data for this code in the RUC data base only reflects a fraction of the total billings. There were 1,727 total billings in the RUC data base mostly performed in the office setting. We estimate that at least twice that were performed on Medicare patients in the hospital setting resulting in a total volume of about 5,100 with most done on Medicare patients. We estimate that perhaps 10,000 are the total volume of procedures.

Specialty Speech-Language Pathology Frequency 4080 Percentage 80.00 %

Specialty Otolaryngology Frequency 1020 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? Yes

If no, please select another crosswalk and provide a brief rationale. 99214

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:92610 Tracking Number Specialty Society Recommended RVU: **1.30**

Global Period: XXX RUC Recommended RVU: **1.30**

CPT Descriptor: Evaluation of oral and pharyngeal swallowing function

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 75 year old out-patient with Parkinson's Disease complains of recent weight loss with limited food intake and increased time in eating. He also has difficulty swallowing some solids, gets food caught in his cheek and exhibits some choking with liquids. An assessment of the structures and functions of swallowing is completed using a variety of liquid consistencies and food textures.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 5%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review medical records, assemble materials for oral-motor examination, prepare materials for swallowing trials

Description of Intra-Service Work: Interview patient, evaluate oral-motor function, assess laryngeal function, evaluate swallowing function with continuum of liquid and solid boluses, introduce compensatory strategies, analyze and interpret results

Description of Post-Service Work: Discuss findings with patient/family, instruct caregiver on compensatory strategies, communicate with referring physician, refer for instrumental assessment if warranted

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009		
Presenter(s):	Jane Dillon, MD, Robert Fifer, PhD, Dee Adams Nikjeh, PhD		
Specialty(s):	Speech-Language Pathology, Otolaryngology		
CPT Code:	92610		
Sample Size:	613	**Resp N:** 130	**Response:** 21.2 %
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**100.00**	250.00	2000.00
Survey RVW:	0.44	1.30	**1.42**	1.70	6.50
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	180.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92610	**Recommended Physician Work RVU: 1.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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 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.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97001	XXX	1.20	**RUC Time**	1,500,000

CPT Descriptor 1 Physical therapy evaluation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90806	XXX	1.86	**RUC Time**	5,500,000

CPT Descriptor 2 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 47 **% of respondents:** 36.1 %

TIME ESTIMATES (Median)	CPT Code: 92610	Key Reference CPT Code: 99203	Source of Time RUC Time
Median Pre-Service Time	7.00	4.00	
Median Intra-Service Time	35.00	20.00	
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	**52.00**	**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	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.50	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	4.00	4.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Speech-Language-Hearing Association (ASHA) conducted a survey of speech language pathologists (SLPs) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) also surveyed ENTs who provide this service. A total of 130 complete responses were received (125 from ASHA and 5 from AAO-HNS). This is the first set of work surveys which SLPs have completed so there is an absence of well-established reference codes for SLP services. (Currently, SLP time is valued only through the practice expense component.) The most frequently selected reference code was Code 99203,new patient office visit, which has an RVW of 1.34 and pre, intra and post time of 4, 20 and 5 minutes respectively .

We are recommending an RVW of 1.42 based on the combined median survey data. We are also recommending professional time of 10 minutes pre, 35 minutes intra, and 10 minutes post time. The pre, intra, and post times recommended are lower than the medians. This results in an IWPUT of about 0.028, which is about half of the IWPUT for 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)

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 Speech-Language Pathology How often? Sometimes

Specialty Otolaryngology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 334000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Speech-Language Pathology Frequency 317300 Percentage 95.00 %

Specialty Otolaryngology Frequency 16700 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? 234,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Speech-Language Pathology Frequency 222300 Percentage 95.00 %

Specialty Otolaryngology Frequency 11700 Percentage 5.00 %

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. 92604

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			92597		92610	
2				Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech		Evaluation of oral and pharyngeal swallowing function	
3	LOCATION	CMS Code	Staff Type	Non-Facility		Non-Facility	
4	GLOBAL PERIOD			XXX		XXX	
5	TOTAL CLINICAL LABOR TIME			0.0		0.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0		0.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0		0.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0		0.0	
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	**End:When patient enters office/facility for surgery/procedure**						
18	SERVICE PERIOD						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure						
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management 99238 –12 minutes, 99239 –15 minutes						
39	Other Clinical Activity (please specify)						
40	**End: Patient leaves office**						
41	POST-SERVICE Period						
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions						
44	*Office visits:*						
45	*List Number and Level of Office Visits*						
46	Other						
47	*Total Office Visit Time*						
48	Other Activity (please specify)						
49	**End: with last office visit before end of global period**						
50	MEDICAL SUPPLIES	CMS Code	Unit				
51	gauze, non-sterile	SG051	item	8		8	
52	gloves, non-sterile	SB022	Item	2		2	
53	patient gown	SB026	item	1		1	
54	lubricating jelly (K-Y) (5gm uou)	SJ032	item	1			
55	chuck pad		item	1			
56	drinking straw	SK020	item	1		2	
57	tongue depressor	SJ061	item	2		2	
58	cup, drinking	SK018	item	1		6	
59	thick-it pack	SJ058	item			4	
60	cookie (each)	SK017	item			2	
61	pre-thickened juice (4 oz uou)	SJ044	item			2	
62	basin, emesis	SJ010	item			1	
63	Equipment	CMS Code					
64	chair with headrest, exam	EF008		1		1	
65	light, fiberoptic headlight	EQ170		1			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Cardiology Services

93307, 93320, and 93325

In September 2007, the RUC made its recommendations for physician work and practice expense for then new code 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography.* Code 93306 is a bundled code comprised of codes 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete*, 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* and 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography).* At that time, the RUC made its practice expense recommendations based on the sum of the codes' parts. The RUC made minor edits to the recommended clinical labor and medical supplies, and the equipment was recommended to remain the same. These recommendations were then forwarded to CMS in 2008 for implementation in 2009.

In the 2009 Final Rule, CMS stated that prior to accepting the RUC's recommendation for code 93306, they would like the RUC to review the practice expense inputs of 93307, 93320, and 93325 to ensure that they are consistent with the recommended direct inputs for 93306. In the interim, they would continue to use the established practice expense RVUs for these services.

In February 2009, the RUC reviewed the practice expense inputs for codes 93307, 93320, and 93325 in comparison with 93306. The RUC understood that the sum of the practice expense inputs of codes 93307, 93320, and 93325 should be greater than the inputs for code 93306 because of economies of scale. The RUC agreed with the specialty's recommendations for clinical labor, medical supplies, and equipment. **The RUC recommends the attached practice expense direct inputs for codes 93307, 93320, and 93325.**

93510 - 93556

As follow-up to a letter sent by the American College of Cardiology (ACC) in the summer of 2008, the ACC addressed the severe discrepancies in Medicare reimbursement for select services performed inside and outside the hospital setting, and had asked that CMS maintain the non-facility practice expense RVUs at the 2008 level until the agency can implement new indirect cost data that is representative of the providers of these services. In September 2008, the CMS then asked the RUC review the practice expense inputs of cardiac catheterization procedures (93510 – 93556) at its February 2009 meeting. At the meeting, ACC maintained that it continues

to agree with the direct practice expense input recommendations submitted by the RUC and accepted by CMS in 2007, and recommended no changes in the direct practice expense at this meeting. **The RUC agreed with the specialty and recommends no changes in the practice expense inputs for CPT codes 93510, 93543, 93545, 93555 and 93556.** The ACC noted that the society is developing a code proposal to re-write cardiac catheterization codes as bundled procedures for initial discussion at the June 2009 CPT Meeting.

93017

As follow-up to a letter sent by the American College of Cardiology (ACC) in the summer of 2008, the ACC addressed the severe discrepancies in Medicare reimbursement for select services performed inside and outside the hospital setting, and had asked that CMS maintain the non-facility practice expense RVUs at the 2008 level until the agency can implement new indirect cost data that is representative of the providers of these services. In September 2008, the CMS then asked the RUC review the practice expense inputs of cardiac catheterization procedures (93510 – 93556) at its February 2009 meeting. At the meeting, ACC maintained that it continues to agree with the direct practice expense input recommendations submitted by the RUC and accepted by CMS in 2007, and recommended no changes in the direct practice expense at this meeting. **The RUC agreed with the specialty and recommends no changes in the practice expense inputs for CPT code 93017.**

1949

CPT Code	CPT Descriptor	Global Period	Recommendation
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	XXX	No Recommendation to Change PE Inputs
93307	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete	XXX	PE Recommendation Only
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete (Use 93320 in conjunction with 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350)	XXX	PE Recommendation Only

CPT Code	CPT Descriptor	Global Period	Recommendation
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) (Use 93325 in conjunction with 76825, 76826, 76827, 76828, 93303, 93304, ~~93307,~~ 93308, 93312, 93314, 93315, 93317, ~~93320, 93321,~~ 93350)	XXX	PE Recommendation Only
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	000	Under CPT Review (No PE recommended change at this time)
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	000	Under CPT Review (No PE recommended change at this time)
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	000	Under CPT Review (No PE recommended change at this time)
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	XXX	Under CPT Review (No PE recommended change at this time)
93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)	XXX	Under CPT Review (No PE recommended change at this time)

1950

December 20, 2008

William L. Rich, MD, FACS
Chair, Relative Value Update Committee
American Medical Association
515 N State St
Chicago IL 60610

Dear Dr. Rich:

The American College of Cardiology (ACC) notes that there was a CMS request to review practice expense inputs for cardiac catheterization procedures (codes 93510-93556) at the January 2009 RUC meeting. This issue was placed on the RUC agenda as the result of a CMS response to a letter sent by ACC in the summer of 2008.

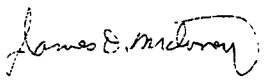
In that letter, the ACC addressed the recent changes in practice expense methodology that had caused a substantial reduction in payment for cardiac catheterization services performed in the physician office setting. In that letter, the ACC stated that it did not challenge the practice expense inputs that had been recommended by the RUC and accepted by CMS in 2007, but did have some concerns about the applications of two policies, one of which is relevant to RUC activities.

CMS has not assigned a technical and professional split for the injection procedures (93539-93545) that accompany the cardiac catheterization procedures, which means that those outpatient cardiac catheterization facilities that are organized and categorized as independent diagnostic testing facilities are unable to receive payment for the technical portion of those services.

It is not the understanding of the ACC that the RUC has ever been asked to deliver an opinion on a technical and professional component split and that this process is automatically performed based on a CMS formula. Therefore, the ACC has not recommended any changes to the practice expense inputs for cardiac catheterization. The ACC asks that the RUC reaffirm this policy that technical and professional component splits are established by CMS and support the ACC recommendation that these injection procedures be assigned such values according to the normal formula.

In addition to the issues identified above, it should be noted that the ACC is currently working to rewrite all of the cardiac catheterization codes as bundled procedures under the direction of the Joint CPT/RUC Workgroup that identified code pairs that are commonly reported together. The ACC intends to submit this proposal in February of 2009 for discussion at the June 2009 CPT Editorial Panel meeting. If the panel approves the changes recommended by the ACC, the existing cardiac catheterization codes will be deleted in 2011.

Sincerely,



James Maloney, MD
RUC Advisor

	A	B	C	D	E	F	G	H	I
1				93307		93320		93325	
2	**Meeting Date: January-February 2009** **Specialty: American College of Cardiology**			**Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete**		**Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete**		**Doppler echocardiogr color flow v mapping (Lis separately in addition to codes for echocardiography)**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non-facility**	**Facility**	**Non-facility**	**Facility**	**Non-facility**	**Facility**
5	**GLOBAL PERIOD**								
6	**TOTAL CLINICAL LABOR TIME**			**61.0**	**0.0**	**19.0**	**0.0**	**11.0**	
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**0.0**	**0.0**	**0.0**	**0.0**	
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**49.0**	**0.0**	**19.0**	**0.0**	**11.0**	
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**4.0**	**0.0**	**0.0**	**0.0**	**0.0**	
10	**TOTAL CLINICAL LABOR TIME CARDIAC SONOGRAPHER**	L050A	Cardiac sonographer	**49.0**	**0.0**	**19.0**	**0.0**	**11.0**	
11	**TOTAL CLINICAL LABOR TIME RN/LPN/MTA**	**L037D**	**RN/LPN/MTA**	**12.0**					
14	PRE-SERVICE								
15	**Start: Following visit when decision for surgery or procedure made**								
19	Other Clinical Activity (please specify) Review prior echo studies	L050A	Cardiac Sonographer	3					
20	Complete pre-service diagnostic and referral forms (*pre-certification*)	L037D	RN/LPN/MTA	5					
21	**End:When patient enters office/facility for surgery/procedure**								
22	SERVICE PERIOD								
23	**surgery/procedure: Services Prior to Procedure**								
24	Review charts *(document clinical elements - patient history)*	L037D	RN/LPN/MTA	1					
25	Greet patient and provide gowning	L037D	RN/LPN/MTA	3					
26	Obtain vital signs	L037D	RN/LPN/MTA	3					
27	Prepare room, equipment, supplies	L050A	Cardiac sonographer	3					
28	Prepare and position patient/ monitor patient/ set up IV	L050A	Cardiac sonographer	3					
29	**Intra-service**								
30	*Acquire ultrasound data*	L050A	Cardiac sonographer	25		14		9	
31	*Process data; measure & record preliminary findings*	L050A	Cardiac sonographer	6		5		2	
32	**Post-Service**								
33	Clean room/equipment	L050A	Cardiac sonographer	3					
34	Other Clinical Activity (please specify) *patient education, instruction, and counseling*	L050A	Cardiac sonographer	2					
35	**End: Patient leaves office**								
36	POST-SERVICE Period								
37	**Start: Patient leaves office/facility**								
38	Other Activity (please specify) *QA documentation required for accreditation*	L050A	Cardiac sonographer	4					
41	**End: Patient leaves office**								

	A	B	C	D	E	F	G	H	I
2	**Meeting Date: January-February 2009** **Specialty: American College of Cardiology**			**Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete**		**Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete**		**Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non-facility**	**Facility**	**Non-facility**	**Facility**	**Non-facility**	**Facility**
54	MEDICAL SUPPLIES		Type						
55	electrode, ECG (single)	SD053	item	3					
56	drape, non-sterile, sheet 40in x 60in	SB006	item	1					
57	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	3					
58	pack, minimum multi-specialty visit	SA048	pack	1					
59	computer media, optical disk 128mb	SK015	item	0.2					
60	videotape, VHS	SK086	item	0.2					
61	ultrasound transmission gel	SJ062	ml	180					
62	Equipment		Type Price						
63	computer, desktop with monitor	ED021	$2,501	25		14		9	
64	video SVHS, VCR (medical grade)	ED034	$1,250	6		5		2	
65	video printer, color (Sony	ED036	$2,295	25		14		9	
66	stretcher	EF018	$1,915	25		14		9	
67	ultrasound, echocardiography	EQ252	$8,000	6		5		2	
68	ultrasound, echocardiography	EQ253	$29,900	6		5		2	
69	ultrasound, echocardiography	EQ254	$248,000	25		14		9	

However, we are currently using the indirect practice cost index (IPCI) associated with cardiology to calculate 95 percent of the rates for these services. Since cardiology has the highest IPCI, these services receive high indirect cost payments relative to almost all other physician fee schedule services. We will review the issue further when we incorporate the data from the new physician practice expense survey currently being conducted by the American Medical Association.

Physician Fee Schedule Payment vs. Outpatient Hospital Payment

Services performed in outpatient cardiac catheterization labs are paid under the physician fee schedule. We must follow the statutory formula for setting payments under this system. Payment for similar services under the hospital Outpatient Prospective Payment System (OPPS) will be different because the law requires that we pay for those services under a different methodology. In addition, we expect that the overhead associated with operating an outpatient hospital would be substantially different from the overhead associated with operating a clinic or other free standing facility such as a cardiac catheterization lab.

AMA RUC

The CMS has worked with the Cardiovascular Outpatient Center Alliance (COCA) extensively this past year in regard to their concerns related to the current and future practice expense RVU calculations associated with cardiac catheterization services. We have met with COCA on numerous occasions to discuss their concerns. In December 2007, COCA provided CMS with their revised direct cost inputs for review. CMS analyzed these data in comparison to the RUC recommended data and did not identify any problems with the direct cost inputs recommended to CMS by the RUC. However, we decided to again request that the RUC review the direct cost inputs for cardiac catheterization services. We informed the RUC that COCA believed that the current RUC process to establish direct cost inputs may not be appropriate for cardiac catheterization services. We requested that the RUC consider these concerns when they send out a level of interest (LOI) solicitation to the specialty societies for these common procedural codes (CPT). To date, CMS has not received any recommended changes from the RUC regarding the direct cost inputs for these services.

However, based on the concerns outlined in your letter, CMS will once again request that the RUC send out another LOI on all of the cardiac catheterization and injection services for review at an upcoming RUC meeting. This will be the third time that CPT codes 93510, 93543, 93545, 93555, 93556, 93307, 93320, 93325, and 93017 have been examined by the RUC.

I appreciate you making us aware of your concerns and hope this information is helpful.

Sincerely,

Jeffrey B. Rich, M.D.
Director
Center for Medicare Management

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
CMS Request

April 2009

Cardiac Device Monitoring

In the 2009 *Final Rule*, CMS stated that these services were not reviewed with the other cardiac device monitoring services, that were reviewed by the RUC in April 2008. CMS requested that these codes, as part of the family of cardiac device monitoring codes, be reviewed.

The RUC reviewed their previous recommendations for the cardiac device monitoring codes from April 2008 and determined that the wearable holter monitor codes may be not be in the proper rank order. The RUC agreed that the recently reviewed device monitoring codes relative values are based on 30 days and the wearable monitor codes, not reviewed as part of this family, are based on 24 hours of work, yet are valued the same. **The RUC recommends that the wearable cardiac monitoring family of codes, 93224-93272, that have work RVUs be referred to CPT for revision and resurvey.**

1960

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
93230	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation	XXX	Refer to CPT Editorial Panel with entire family of codes 93224-93272
93233	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; physician review and interpretation	XXX	Refer to CPT Editorial Panel with entire family of codes 93224-93272

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2009

Measure Blood Oxygen Level

In October 2008 the RUC's Five Year Identification Workgroup reviewed 94762 *Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)* as part of the CMS Fastest Growing Procedures screen and noted that it consists of practice expense only, with independent testing facilities predominantly performing this procedure. The Workgroup recommended that this code and the other codes in the family (94760 *Noninvasive ear or pulse oximetry for oxygen saturation; single determination* and 94761 *Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)*) be referred to the RUC's Practice Expense Subcommittee for review of the direct practice expense inputs.

In January 2009 the RUC carefully reviewed the typical clinical labor, medial supplies, and equipment recommended by the specialty society for codes 94760, 94761, and 94762. The RUC made few edits and changes and agreed with the modified specialty recommendations. **The RUC recommends the attached direct practice expense inputs for codes 94760, 94761, and 94762.**

1961

CPT Code	CPT Descriptor	Global Period	Recommendation
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	XXX	Practice Expense Inputs Only
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)	XXX	Practice Expense Inputs Only
94762	Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)	XXX	Practice Expense Inputs Only

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:
94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)
94762 Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)

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. There is good practice-type and geographical representation with the two pulmonary groups involved.

Please describe the clinical activities of your staff:
Pulse oximetry is performed to monitor saturation of arterial blood oxygen levels and heart rate to assess patient oxygenation and monitor treatment and interventions, requiring physician oversight and the adherence of staff following protocol. Pulse oximetry is performed by trained personnel in a variety of settings, for example, hospitals, clinics, office and home.
94760 (single) and 94761 (multiple) and 94762 (overnight)
Pre-Service Clinical Labor Activities:

- Obtain a physician's order including indication for monitoring and alarm limits for multiple determinations or overnight monitoring.
- A focus history is taken, and vital signs obtained.

Intra-Service Clinical Labor Activities:

- Remove blue, black, green or any metallic flaked nail polish with an acetone pad.
- The age-appropriate sensor is selected and placed appropriately on an area where light passes through a capillary bed. In adult patients, the sensors may be placed on the ear, finger, toes or feet.
- Perfusion at the sensor site is assured by signal strength, plethysomograph waveform or perfusion readings on the pulse oximeter.
- The patients palpable pulse rate is compared with the pulse rate indicated on the pulse oximeter.
- Sensor site should be periodically checked and changed if indicated, per manufactures recommendation depending on the site used (every 2 - 8 hours).
- For multiple determinations and overnight monitoring (94761 and 94762), Hi and Low alarm limits must be set. Alarm volume and alarm delay must also be set.

Post-Service Clinical Labor Activities:

- Document the SpO2 findings and the clinical decisions based on the measurement in the medical record, detailing the conditions under which the readings were obtained: probe site, inspired oxygen concentration or flow, and alarms settings.
- In addition, for 94762 overnight pulse oximetry data is downloaded and evaluated. This becomes part of the patient's medical record.

	A	B	C	D	E	F	G	H	I
1				94760		94761		94762	
2	Meeting Date: January 29 - February 1, 2009 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Noninvasive ear or pulse oximetry for oxygen saturation; single determination		Noninvasive ear or pulse oximetry for oxygen saturation; multiple deteriminations (eg, during exercise)		Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)	
3	LOCATION	Code	Type	Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX		XXX		XXX	
5	TOTAL CLINICAL LABOR TIME			4.0	0.0	7.0	0.0	21.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			4.0	0.0	7.0	0.0	21.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0
9	PRE SERVICE								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms								
12	Coordinate pre-surgery services								
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	SERVICE PERIOD								
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
20	Review charts								
21	Greet patient and provide gowning	L047C	RN/RT	1		1		1	
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	**Intra-service**								
29	Assist physician in performing procedure	L047C	RN/RT	2		5			
30	Downloading Data							20	
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	L047C	RN/RT	1		1		1	
37	Review/read X-ray, lab, and pathology reports								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
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								
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						
53	*Total Office Visit Time*			0	0	0	0	0	0
55	**End: with last office visit before end of global period**								
56	MEDICAL SUPPLIES								
57	oximetry sensor wrap	SD104						1	
58	adhesive remover, pad (acetone)	SG006		1		1		1	
59	swab-pad, alcohol	SJ053		1		1		1	
60	paper, laser printing (each sheet)	SK057						2	
61	Equipment								
62	pulse oximeter with printer	EQ211	1	1		1		1	
63	Pulse oximeter recording software	EQ212	1					1	

AMA
AMERICAN
MEDICAL
ASSOCIATION

May 27, 2009

Amy Bassano
Director
Hospital and Ambulatory Policy Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: HCPAC Recommendations

Dear Ms. Bassano:

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 the American Speech Language Hearing Association/CMS Request codes for CPT 2010.

These work relative value and direct practice expense input recommendations address Speech-Language Pathology codes 92526 *Treatment of swallowing dysfunction and/or oral function for feeding* and 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording*.

The RUC HCPAC Review Board looks forward to continued CMS representation at our meetings and your effort to ensure a fair review of the enclosed recommendations.

If you have any questions please contact AMA staff, Susan Clark, at (202) 789-7495 or via e-mail at Susan.Clark@ama-assn.org.

Sincerely,

Arthur R. Traugott, MD

Lloyd S. Smith, DPM

cc: Rick Ensor
Edith L. Hambrick, MD
Whitney May
Ken Simon, MD
Pam West, DPT
Susan Clark
Sherry Smith

AMA/Specialty Society RVS Update Committee
Health Care Professionals Advisory Committee
Summary of Recommendations
CMS Request

February 2009 and April 2009

Speech-Language Pathology Services

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech-language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech-language pathologists will be able to bill Medicare independently as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation, speech-language pathology services be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech-language pathology codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech-language pathology codes over the course of the CPT 2010 and CPT 2011 cycles.

1967

92611

In February 2009, the HCPAC reviewed the American Speech-Language-Hearing Association (ASHA) recommendation for 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording.* The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined that 7 minutes of pre-service time appropriately accounted for the time required to review the patients medical records, review the patient history, prepare the barium liquids, prepare items of different consistencies, and dress in the appropriate radiation deterrent gowns. The HCPAC reviewed the intra-service time and determined that 30 minutes appropriately accounted for the time to feed the patient the numerous substances while watching the video fluoroscopy and make determinations on the subsequent liquid consistencies to utilize and patient posture to employ. The HCPAC reviewed the immediate post-service time survey results and recommended reducing the time from 15 minutes to 10 minutes. The HCPAC determined that 10 minutes of immediate post-operative time appropriately accounts for time required discussing findings with the patient/family, writing a report and communicating necessary information with the referring physician.

The HCPAC compared 92611 to 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service, and 10 minutes immediate post-service time). The HCPAC determined that 92611 is more intense than 97001 and 92602 as more management and follow-up strategy determination is required.

The HCPAC also compared 92611 to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.34, pre-service time = 4 minutes, intra-service time = 20 minutes and immediate post-service time = 5 minutes), and determined that the survey 25th percentile work RVU of 1.34 is identical to 99203 and appropriately accounts for the work required to perform this service. **The HCPAC recommends a work RVU of 1.34 for code 92611.**

In April 2009, the HCPAC reexamined code 92611 to assure no rank order anomaly exists with the two codes which were reviewed at the RUC in February 2009 (92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* (RUC recommended work RVU = 1.48) and 92610 *Evaluation of oral and pharyngeal swallowing function* (RUC recommended work RVU = 1.30). **The HCPAC reaffirmed the recommended physician work RVU of 1.34 for code 92611 which was reviewed in February 2009.**

1968

92526

At the February 2009 HCPAC meeting the HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding.* After a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommended postponing recommending a work value for this service until additional frequency data was gathered, the length of treatment session was defined and the RUC had reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function.*

In April 2009, the HCPAC reviewed code 92526 and determined that it is typically performed 10 times to treat dysphagia in the outpatient setting, approximately once a week. The HCPAC recognized that since this speech-language pathology service is converting from practice expense only inputs to work, that survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined to decrease the surveyed pre-time to 5 minutes as it appropriately accounts for the time required to review the previous progress note and prepare the materials. The HCPAC reviewed the intra-service time and determined that 45 minutes appropriately accounted for the time to instruct a variety of oral motor and pharyngeal/laryngeal swallow exercises and assess the patient's ability to achieve criterion performance levels of a variety of therapy activities. The HCPAC

reviewed the immediate post-service time and agreed with the specialty society recommended reduction to 5 minutes. The HCPAC determined that 5 minutes appropriately accounts for time required discussing findings with the patient/family and writing a report.

The HCPAC compared 92526 to codes 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 97003 *Occupational therapy evaluation* (work RVU = 1.20, 7 minutes pre-service, 45 minutes intra-service, and 5 minutes immediate post-service time). The HCPAC determined that 92526 is more intense than 97001 and 92602 as the type of patient is more fragile and typically cognitively impaired/post CVA. **The HCPAC recommends a work RVU of 1.34 for code 92526.**

Practice Expense
The HCPAC recommends removing the previous speech-language pathologist's time from the practice expense inputs for codes 92526 and 92611, as well as replacing outdated recording output VHS tape with a DVD for the non-facility setting for code 92611.

PLI
The HCPAC recommends that codes 92526 and 92611 be crosswalked to 92557.

1969

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
92526	Treatment of swallowing dysfunction and/or oral function for feeding	XXX	1.34
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	XXX	1.34

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92526 Tracking Number Specialty Society Recommended RVU: **1.34**

Global Period: XXX RUC Recommended RVU: **1.34**

CPT Descriptor: Treatment of swallowing dysfunction and/or oral function for feeding

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year-old male patient, 1 week post-CVA, presents with swallowing dysfunction contributing to weight loss, choking and possible aspiration. The treatment plan calls for treatment of oral and pharyngeal phase problems.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review of previous progress note, preparation of materials

Description of Intra-Service Work: Interview of patient re: past home practice. Instruct in variety of oral motor and pharyngeal/laryngeal exercises and assess patient's ability to perform each in 2 sets of 10.

Description of Post-Service Work: Discuss progress with patient/family, write note, write home exercises for patient

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	Dee Adams Nikjeh, PhD, Robert Fifer, PhD				
Specialty(s):	Speech-Language Pathology				
CPT Code:	92526				
Sample Size:	575	**Resp N:**	121	**Response:** 21.0 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	60.00	**200.00**	600.00	3250.00
Survey RVW:	0.01	0.90	**1.34**	1.50	5.67
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30), 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92526	**Recommended Physician Work RVU: 1.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
97001	XXX	1.20	**RUC Time**	1,500,000

CPT Descriptor 1 Physical therapy evaluation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90806	XXX	1.86	**RUC Time**	5,500,000

CPT Descriptor 2 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 29.7 %

TIME ESTIMATES (Median)	CPT Code: 92526	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	45.00	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	**55.00**	**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	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	5.00	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 IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Speech-Language-Hearing Association (ASHA) conducted a survey of speech language pathologists (SLPs). A total of 121 complete responses were received. This is the first set of work surveys which SLPs have completed so there is an absence of well-established reference codes for SLP services. (Currently, SLP time is valued only through the practice expense component.). The most frequently selected reference code was Code 99214, established office visit, which has an RVW of 1.42 and pre, intra and post time of 5, 25, and 10 minutes.
We are recommending an RVW of 1.34 based on the median RVW of the survey responses. We are also recommending professional time of 5, 45, and 5 minutes respectively. We are recommending a reduction of the median pre and post survey time to 5 minutes each. This code is done a number of times for an individual patient and there is an economy of scale in the pre and post time which the survey respondents might not have fully factored into their estimate. We do believe that the median survey estimate for intra time is a very reasonable estimate. This results in an IWPUT of 0.025 which is about a little over half of the IWPUT of the selected reference code (0.045).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Speech-Language Pathology 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? 1933691
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.
Please explain the rationale for this estimate. We used the Medicare number and added 25% to estimate the number of times this might be performed nationally.

Specialty Speech-Language Pathology Frequency 1933691 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? 1,546,953 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number came from 2002 Medicare information

Specialty Speech-language pathology Frequency 1546953 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. 92557

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:92611 Tracking Number Specialty Society Recommended RVU: **1.50**

Global Period: XXX RUC Recommended RVU: **1.34**

CPT Descriptor: Motion fluoroscopic evaluation of swallowing function by cine or video recording

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 75 year old out-patient 3 weeks post-stroke was found on clinical exam to exhibit breathy vocal quality and signs and symptoms suggesting oral- pharyngeal dysfunction with characteristics of aspiration. He has been on a modified diet with thickened liquids and pureed foods since that exam. Assessment of the oral and pharyngeal phases is completed in order to recommend a diet and any necessary compensatory and therapeutic techniques.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review of medical records, preparation of barium materials, prep and position the patient

Description of Intra-Service Work: Interview patient, present continuum of materials and try appropriate compensatory techniques for identified physiologic deficits, obtain lateral and A-P views, review video recording, analyze results

Description of Post-Service Work: Discuss findings with patient/family, write report, communicate with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2009				
Presenter(s):	Dee Adams Nikjeh, PhD, Robert Fifer, PhD				
Specialty(s):	Speech-Language Pathology				
CPT Code:	92611				
Sample Size:	279	**Resp N:**	55	**Response:** 19.7 %	
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**100.00**	200.00	1440.00
Survey RVW:	0.80	1.34	**1.50**	1.83	4.80
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**30.00**	45.00	90.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(30); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	92611	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

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	Work RVU	Time Source	Most Recent Medicare Utilization
97001	XXX	1.20	**RUC Time**	1,500,000

CPT Descriptor 1 Physical therapy evaluation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90806	XXX	1.86	**RUC Time**	5,500,000

CPT Descriptor 2 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 38.1 %

TIME ESTIMATES (Median)	CPT Code: 92611	Key Reference CPT Code: 99214	Source of Time RUC Time
Median Pre-Service Time	7.00	5.00	
Median Intra-Service Time	30.00	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	**47.00**	**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	5.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	5.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.00
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	3.00
Outcome depends on the skill and judgment of physician	5.00	4.00
Estimated risk of malpractice suit with poor outcome	4.00	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	5.00	4.00
Post-Service intensity/complexity	4.00	4.00

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Speech-Language-Hearing Association (ASHA) conducted a survey of speech language pathologists (SLPs) who provide this service. A total of 56 complete responses were received. This is the first set of work surveys which SLPs have completed so there is an absence of well-established reference codes for SLP services. (Currently, SLP time is valued only through the practice expense component.). The most frequently selected reference code was Code 99214 established patient office visit, which has an assigned RVW of 1.42 and pre, intra and post time of 5, 25 and 10 minutes respectively .

We are recommending an RVW of 1.50 based on the median survey data and the complexity and the risk of the service. We are recommending an RVW of 1.50 based on the median survey data, as well as the complexity and risk of the service. The procedure is performed by a speech-language pathologists specializing in dysphagia, that is, not by all speech-language pathologists. There is a great risk to the patient if the evaluation is not performed correctly because an incorrect diagnosis can lead to faulty intervention not to mention the possibility of aspiration pneumonia. We are also recommending professional time of 10, 30 and 15 minutes post time. This results in an IWPUT of about 0 031 which is about one-quarter less than the IWPUT for the reference code although the surveyed code was rated more complex.

SERVICES REPORTED WITH MULTIPLE 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 92611 is reported with 74230 Swallowing function, with cineradiography/videoradiography. The RUC database shows a work RVU of 0.52 and 12 minutes total physician time for the radiological service with no differentiation of pre, intra, and post times. The speech-language pathologist's procedure is independent of that of the radiologist.

3.

CPT	Global Period	Work RVU	Total Time
74230	XXX	0.52	12 minutes

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Speech-Language Pathology 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? 467200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Speech-Language Pathology Frequency 467200 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? 359,375 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Speech-Language Pathology Frequency 359375 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. 92557

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**92526**		**92611**	
2				**Treatment of swallowing dysfunction and/or oral function for feeding**		**Motion fluoroscopic evaluation of swallowing function by cine or videc recording**	
3	**LOCATION**	**CMS Code**	**Staff Type**	**Non-Facility**		**Non-Facility**	
4	**GLOBAL PERIOD**			**XXX**		**XXX**	
5	**TOTAL CLINICAL LABOR TIME**			**0.0**		**0.0**	
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**		**0.0**	
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**		**0.0**	
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**		**0.0**	
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	**End:When patient enters office/facility for surgery/procedure**						
18	SERVICE PERIOD						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	Review charts						
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Assist physician in performing procedure						
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment by physician staff						
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management 99238 –12 minutes, 99239 –15 minutes						
39	Other Clinical Activity (please specify)						
40	**End: Patient leaves office**						
41	POST-SERVICE Period						
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions						
44	*Office visits:*						
45	*List Number and Level of Office Visits*						
46	Other						
47	*Total Office Visit Time*						
48	Other Activity (please specify)						
49	**End: with last office visit before end of global period**						
50	MEDICAL SUPPLIES	CMS Code	Unit				
51	gauze, non-sterile	**SG051**	item	**3**			
52	gloves, non-sterile	**SB022**	Item	**1**		**1**	
53	apple sauce	**SK004**	item	**1**		**1**	
54	computer media, dvd	**SK013**	item			**1**	
55	cookie (each)	**SK017**	item			**2**	
56	cup, drinking	**SK018**	item	**2**		**1**	
57	drinking straw	**SK020**	item	**2**		**1**	
58	graham crackers (one packet)	**SK040**	item	**3**			
59	juice, apple	**SK042**	item	**1**			
60	spoon, plastic	**SK077**	item	**2**		**4**	
61	swab, lemon-glycerine (3 pak uou)	**SJ051**	item	**3**			
62	swab-pad, alcohol	**SJ053**	item	**1**			
63	tongue depressor	**SJ061**	item	**2**		**1**	
64	thick-it pack	**SJ058**	item	**3**		**1**	
65	barium, honey (Varibar)	**SH017**	ml			**30**	
66	barium, nectar (Varibar)	**SH018**	ml			**30**	
67	barium, pudding (Varibar)	**SH019**	ml			**30**	

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			92526		92611	
2				Treatment of swallowing dysfunction and/or oral function for feeding		Motion fluoroscopic evaluation of swallowing function by cine or video recording	
3	LOCATION	CMS Code	Staff Type	Non-Facility		Non-Facility	
68	Equipment	CMS Code					
69	none			0			
70							